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A. Needs Assessment Process – Wisconsin's 2005 Five-Year Needs Assessment

Wisconsin's 2005 five-year needs assessment process identified the need for: preventive and primary care services for pregnant women; preventive and primary care services for children; and services for CSHCN by following the conceptual framework to:

1) Assess need,
2) Examine capacity,
3) Select priorities,
4) Set targets,
5) Identify activities,
6) Allocate resources, and
7) Monitor progress.

Wisconsin recognizes that identifying "need" among its maternal and child health population is a continuous and ongoing process.

B. Five Year Needs Assessment

B.1 Process for Conducting Needs Assessment

Listening Sessions Set the Stage

During September 2003 through January 2004, 16 MCH/CSHCN Listening Sessions (face-to-face and teleconferences) were conducted to "learn from the past, and gather ideas for future MCH programming". The reason for gathering this information was to help establish the foundation for Wisconsin's five year needs assessment planning process. Insightful qualitative information was gathered from over 350 individuals who shared their input and perspective on three questions:

1) What are the maternal, child, and family health needs (including children with special health care needs) in Wisconsin?
2) What particular issues/needs should statewide projects focus on in 2005-2009?
3) Based on your experiences with the MCH/CSHCN Program, what lessons have you learned or observed that you could share with us?

The Listening Sessions targeted: local health departments directors at Wisconsin Association of Local Health Departments and Boards; existing coalitions and advisory groups (MCH Coalition, MCH Advisory, Public Health Advisory, and WIC Advisory); parents; DPH regional office staff; DPH Family Health Section staff; current grantees; and potential or interested applicants including agencies who have other HRSA/MCHB grants.

Findings from the 2004 Listening Sessions consistently identified oral health and dental access, nutrition and overweight and obesity, and mental health across all maternal and child health

population groups. Other needs that were mentioned less frequently, yet often enough to be noticed were: injury, family planning especially STIs, infant mortality, asthma, and diabetes.

Overarching issues consistently emerged despite the diversity among Listening Session participants. The issue of access to health care was consistently raised, in particular as it pertains to the needs of undocumented individuals and immigrants. Tied to the access issue is the growing concern and need for accessible and quality translation services for non-English speaking people. The need to find interpreters, as well as train them, to accurately translate medical information is expected to continue.

A recurring concern is the increase in health disparities among maternal and child health populations, particularly among African American and Native American populations. In addition many providers, recognizing the integral role that schools play in the health of children, expressed their concern about the disconnect with schools. Lastly, the importance of a medical home for all children was frequently cited.

Needs Assessment Methodology: Assessing the Need and Involving Partners

Wisconsin used a well-defined, open, inclusive, and participatory process for assessing the MCH/CSHCN needs in the state. First, the Listening Sessions set the stage as they provided qualitative data, personal stories and information from people who were familiar with issues surrounding the maternal and child health population. Partners involved in Wisconsin's needs assessment process included representatives from (the):

Public
- College and University
- Regional CSHCN Centers

Private
- Family Planning/Reproductive Health Clinics
- Hospitals and Clinics
- Professional Organizations: Wisconsin Association for Perinatal Care, March of Dimes, and, Sudden Infant Death Center

Levels of Government
- Local Health Departments
- State Division of Public Health
- DPH Regions
- Department of Public Instruction (DPI)
- Birth to Three Program
- UW Extension

Advisory Groups
- MCH Program Advisory Committee
- WIC Advisory Committee

Citizen and Family Members
- Advocacy Organizations
- Parents (on the MCH Advisory Committee)

In addition to the Listening Sessions, two major statewide initiatives enhanced and shaped our needs assessment process: Wisconsin's State Health Plan entitled, *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*, and *KidsFirst: The Governor's Plan to Invest in Wisconsin's Future, 2004.* A partnership between government, the people, and the public, private, and voluntary sectors is necessary. Many of the maternal and child health problems and needs were initially defined in *Healthiest Wisconsin 2010.* All related documents of the State Health Plan are available on CD-ROM. Wisconsin's State Health Plan embraces two overarching partnership principles that influenced the Title V MCH/CSHCN Needs Assessment process: 1) It takes the work of many to protect the health for all, and 2) Broad-based sustainable partnerships are needed to prepare and respond to the 21st century challenges affecting the public's health.

A "potential" MCH/CSHCN list of needs was drafted, refined and eventually expanded to reflect over 40 different problems or needs. Family Health Section staff finalized the list using both quantitative and qualitative information and data on the health status of Wisconsin's maternal and child population including children with special health care needs. In the end, we identified a total of 44 different problems/needs in Wisconsin for our maternal and child health population.

All 44 problems/needs are linked to the federal *Healthy People 2010*, *Healthiest Wisconsin 2010*, and the Title V National and State Performance Measures. This information was provided to stakeholders as background materials to help them in their Q-Sort decision making process *(see Attachment A - Related Objectives)*.

Family Health Section epidemiologists and program experts prepared a data "detailed picture" to reflect each need. The 44 data detail sheets are included at the end of Section B3. Each data detail sheet includes the:

- Definition of the problem/need
- Description of the need
- Relationship to National and State goals
- Data depiction with charts and graphs, and
- References

The epidemiologists examined and simplified a large body of quantitative local, state and/or national data to describe the incidence and the prevalence of health conditions related to the 44 needs. The indicators used to define the problem/need in Wisconsin included demographic measures, health status measures, and outcome measures. A variety of data sources were used including Census and Vital records, surveillance data including SLAITS, BRFSS, YRBS, PedNSS, communicable disease incidence data, data from surveys and questionnaires, program and service data, and data from the Listening Sessions.

44 Identified MCH/CSHCN Needs

1. Access to health care for children
2. Health insurance coverage
3. CSHCN and families in decision making and satisfied with services
4. CSHCN receive care within a Medical Home
5. CSHCN have adequate insurance
6. CSHCN and families access to community services
7. Youth with SHCN transition to adulthood
8. CSHCN access to dental care
9. Unintentional childhood injuries
10. Child abuse and neglect
11. Falls
12. Motor vehicle deaths and hospitalizations
13. Child passenger safety
14. Intentional childhood injuries
15. Suicide
16. Homicide
17. Teen births
18. Unintended pregnancy
19. Contraceptive services
20. Abstinence from adolescent sexual activity
21. First trimester prenatal care
22. Infant mortality
23. Low birth weight
24. Newborn hearing screening
25. Breastfeeding initiation and duration
26. Sudden Infant Death Syndrome (SIDS)
27. HIV/AIDs
28. Asthma hospitalization for children
29. Dental caries
30. Blood lead levels in young children
31. Immunizations in young children
32. Overweight and at risk for overweight
33. Infant and early childhood mental health
34. Adolescent mental health
35. Women's mental health/depression
36. STIs, chlamydia and gonorrhea
37. Fruit and vegetable consumption
38. Physical activity
39. Smoking among pregnant women
40. Tobacco use among youth
41. Alcohol use
42. New parent home visitation
43. Folic acid knowledge and use
44. Comprehensive school health programming

Healthiest Wisconsin 2010 previously set the stage calling for coordination of state and local public health partnerships. In order to be successful, the MCH/CSHCN needs assessment engaged the community of interest through partners or stakeholders. A letter was sent to over 175 people with expertise in the health of women, children, adolescents, and/or children/families with special health care needs inviting them to participate as "stakeholders" in the Title V needs assessment process. Interested stakeholders were asked to attend a training to understand the MCH/CSHCN needs assessment process and to learn the Q-Sort technique, review the 44 data "detailed pictures" and participate in ranking the selected needs in priority order using the Q-Sort method. Stakeholders were also invited to identify additional needs and provide appropriate information for any additional data detail sheets. Stakeholders participated in an online WisLine Web training to understand the needs assessment process and to learn the Q-Sort technique for reviewing and prioritizing the data. (WisLine Web training is a telephone/computer training that can be done from your office or anywhere you have access to a telephone and computer.) Stakeholders also had the option to access and view the archived version of the training at a later date.

From the 175 people contacted, initially 90 individuals agreed to participate as stakeholders but in the end 65 people completed the Q-Sort process and returned their ranked Q-Sort logs. Four

responses were dropped because of unresolved errors and late submission. The stakeholders included a number of individuals from the MCH Advisory Committee. The stakeholder's geographic location in the state, their agency representation and area of specialty were elements considered in the final selection.

The Q-Sort analysis was completed by an intern with the Wisconsin Maternal and Child Health (MCH) LEND Program who was also getting his master's degree from the University of Wisconsin - School of Social Work. The Q-Sort individual responses were transferred to an Excel spreadsheet and analyzed for accuracy. Four individual responders were asked to correct inaccurate number responses or duplicate responses. The data set was exported into SPSS and recoded for analysis. The analysis included a mean and standard deviation for each need and frequency tables for geography, agency, and specialty areas. A second analysis was done to check for bias, taking into consideration the different (self-identified) specialty areas represented; that is eight people self identified as experts in adolescent health, ten people in CSHCN, and thirty people in general MCH. This analysis indicated only a slightly different mean ranked order from the first analysis conducted.

Utilizing the Q-Sort results, the list of 44 problems/needs was narrowed down to 20. The top 20 needs are listed in the following table and appear in the shaded cells.

Results of Q-Sort Analysis
20 MCH/CSHCN Needs
(Shaded Cells)

1. Access to health care for children	23. Low birth weight
2. Health insurance coverage	24. Newborn hearing screening
3. CSHCN and families in decision making and satisfied with services	25. Breastfeeding initiation and duration
4. CSHCN receive care within a Medical Home	26. Sudden Infant Death Syndrome (SIDS)
5. CSHCN have adequate insurance	27. HIV/AIDs
6. CSHCN and families access to community services	28. Asthma hospitalization for children
7. Youth with SHCN transition to adulthood	29. Dental caries
8. CSHCN access to dental care	30. Blood lead levels in young children
9. Unintentional childhood injuries	31. Immunizations in young children
10. Child abuse and neglect	32. Overweight and at risk for overweight
11. Falls	33. Infant and early childhood mental health
12. Motor vehicle deaths and hospitalizations	34. Adolescent mental health
13. Child passenger safety	35. Women's mental health/depression
14. Intentional childhood injuries	36. STIs, chlamydia and gonorrhea
15. Suicide	37. Fruit and vegetable consumption
16. Homicide	38. Physical activity
17. Teen births	39. Smoking among pregnant women
18. Unintended pregnancy	40. Tobacco use among youth
19. Contraceptive services	41. Alcohol use
20. Abstinence from adolescent sexual activity	42. New parent home visitation
21. First trimester prenatal care	43. Folic acid knowledge and use
22. Infant mortality	44. Comprehensive coordinated school health programming

The Family Health Section staff reviewed the results and further studied the top 20 needs that received the cumulative highest score from the Q-Sort results. Everything remained with the exception of the need "Immunization in Young Children". We replaced this need with the "CSHCN Care within a Medical Home" need because childhood immunization is addressed and funded by the Bureau of Communicable Diseases and Preparedness. The Family Health Section epidemiologists and program experts expanded the data detailed sheets for the 20 needs to include additional quantitative data describing the seriousness of the problem and referencing health status and capacity indicator data. See Section B3 for the 44 data detail sheets organized by the maternal and child health populations.

The next phase of the needs assessment process proceeded with 30 self identified stakeholders attending a one-day meeting in Madison on March 30, 2005 to review the Q-Sort results and achieve consensus to further narrow down the list of 20 needs to Wisconsin's top 10 needs *(see Attachment B - (B1) Stakeholder Training, (B2) Setting Priorities, and (B3)Participants List)*.

The meeting agenda included a review of the Q-Sort analysis and training on reaching consensus.

At this meeting, stakeholders were divided into one of three population-based groups determined by their expertise and interest: Women and Infants, Children and Adolescents, and CSHCN. Each group was asked to rank the problems/needs by considering:

- Size of the problem
- Seriousness of the problem, and
- Potential for prevention

This group process allowed for discussion on the quantitative data but also encouraged stakeholders to present qualitative data describing personal stories of situations and examples of the problems and needs in the local community. The following summary highlights the day's results from highest need to lowest need within each population group. Many of the needs received equal rankings within a population group. Consensus was achieved within each population group only.

Results from March 30, 2005 Stakeholders Meeting Ranked Priority Score by Population Group		
Women and Infants	**Children and Adolescents**	**CSHCN**
Infant mortality (75)	Contraceptive services (70)	Infant mortality (60)
Low birth weight (75)	Unintended pregnancy (60)	Low birth weight (60)
Unintended pregnancy (75)	Infant and early childhood mental health (60)	Dental caries (60)
Access to health care for children (70)	Dental caries (56)	CSHCN receive care within a medical home (60)
Health insurance coverage (70)	Tobacco use among youth (56)	Child abuse and neglect (56)
Smoking among pregnant women (70)	Child abuse and neglect (52)	Adolescent mental health (56)
Contraceptive services (70)	Teen births (48)	CSHCN have adequate insurance (48)
Child abuse and neglect (60)	Adolescent mental health (48)	Infant and early childhood mental health (48)
First trimester prenatal care (48)	Overweight and at risk for overweight (48)	Intentional childhood injuries (48)
Women's mental health/depression (48)	Unintentional childhood injuries (48)	Access to health care for children (33)
Overweight and at risk for overweight (48)	Intentional childhood injuries (48)	Health insurance coverage (33)
Dental caries (48)	Access to health care for children (44)	Overweight and at risk for overweight (33)
Infant and early childhood mental health (33)	Health insurance coverage (44)	
Intentional childhood injuries (16)	First trimester prenatal care (44)	

To finalize the process of selecting priorities, Family Health Section staff met to review the ranked results by population group and to identify possible solutions to the problems and needs. A list was created that combined the rankings of the three population groups as follows:

- Infant mortality
- Contraceptive services
- Low birth weight
- Unintended pregnancy
- Infant and early childhood mental health
- Dental caries
- Access to health care for children
- CSHCN receive care within a medical home
- Health insurance coverage
- Tobacco use among youth
- Child abuse and neglect
- Smoking among pregnant women
- Adolescent mental health
- Teen births
- CSHCN have adequate insurance
- First trimester medical care
- Overweight and at risk for overweight
- Intentional childhood injuries
- Women's mental health and depression
- Unintentional childhood injuries

Family Health Section staff identified possible strategies or activities that will help Wisconsin move toward addressing the needs because it is not enough to agree that something is a problem. We must have a reasonable strategy for addressing the problem in order for it to rise to the level of a priority need or a Wisconsin State Performance Measure. The public health assurance function is carried out in many ways or approaches from: providing services directly, contracting services, developing legislation, educating professionals and consumers, building systems, and/or improving data capacity. Staff considered effectiveness, efficiency and acceptability based on their experience and insight regarding what can work – within the sphere of control in state government.

1. Effectiveness:
   How effective is this to leading to a solution?
   Is it reachable by known interventions?
   Can it be tracked and measured?
   What are the health consequences of not implementing such a strategy/activity?
2. Efficient:
   How efficient is this to leading to a solution?
   Does the solution produce a result with a minimum of effort, expense, or waste?
   Is this appropriate use of Title V, Block Grant dollars?

3. Acceptable:
How acceptable is this strategy/activity to clients, providers, and within state government?
What is the degree of demographic, racial, and ethnic disparity?
Does this solution help achieve a *Healthiest Wisconsin 2010* Health Priority?
Does this solution help promote the Governor's *KidsFirst* Initiative?

On May 3, 2005, Family Health Section staff reached consensus on the top 10 priority needs for the state. This was accomplished by focusing discussion on the effectiveness, efficiency, and acceptability to address each need and by regrouping and organizing similar needs that fall within with the priority areas in the *Healthiest Wisconsin 2010.* The following grid displays how the top 10 needs fit with the *Healthiest Wisconsin 2010* priorities, National Performance Measures, and the existing State Performance Measures. We used this grid to revise existing State Performance Measures and create new State Performance Measures. (See Section E.)

Draft Results May 3, 2005 FHS Staff Needs Assessment Meeting			
Wisconsin's Top 10 Needs	**Healthiest Wisconsin 2010 Priorities**	**National Performance Measures**	**Existing State Performance Measures**
1.Disparities in Birth Outcomes • Infant mortality • LBW • Preterm • Early Prenatal care	Access to primary and preventive health services	Percent VLBW Percent VLBW delivered at facilities for high risk First trimester prenatal care	Ratio of black infant mortality to white infant mortality
2. Contraceptive Services • Unintended pregnancy • Teen births • Abstinence from adolescent sexual activity	High risk sexual behavior	Rate of births among teenagers 15 – 17	Risk for unintended pregnancy
3. Mental Health for all populations groups	Mental health and disorders	Rate of deaths from suicide among 15 – 19	
4. Medical Home for all children	Access primary and preventive health services	CSHCN receive care within a medical home	
5. Dental Health (including CSHCN, racial/ethnic, linguistic, and geography, income)	Access primary and preventive health services	Percent of third graders who have protective sealants	Percent of children 6 – 8 with untreated decay in primary and permanent teeth
6. Health Insurance and Access to Health Care	Access primary and preventive health services	Percent of children without health insurance	Percent of children <12 who receive a physical exam a year
7. Smoking and Tobacco Use • Youth • Pregnant Women	Tobacco use and exposure		Percent of women who use tobacco during pregnancy
8. Intentional childhood Injuries • Child Abuse and Neglect	Intentional and unintentional injury and violence	Rate of deaths from suicide among 15 – 19	
9. Unintentional Childhood Injuries	Intentional and unintentional injury and violence	Rate of deaths to children 14 years and younger from motor	Rate of deaths among youth 15 – 19 due to motor vehicle crashes

		vehicle crashes	
10. Overweight and At Risk for Overweight	Overweight, obesity and lack of physical activity	Percent of mothers who breastfeed their infants at hospital discharge	Percent of children 2 – 4 years who are overweight

Interestingly, 8 of the top 10 needs were also identified during the 2004 Listening Session: health disparities, family planning access (contraceptive services), mental health, medical home, dental health, health insurance and health care access, injury (intentional and unintentional), and overweight. The similar results give both processes validity. Also, each priority need aligns within the priorities of the Governor's *KidsFirst Initiative*.

Comparison of Wisconsin's Top Ten Needs
2000 and 2005

Year 2000 Needs	Year 2005 Needs
1.Health disparities…….	1. Disparities in birth outcomes
2.Teen pregnancy……...	2. Contraceptive services
	3. Mental health for all
	4. Medical home for all
3.Dental access and care……	5. Dental health including CSHCN
4.Health access……..	6. Health insurance and access to health care
5.ATODA …….	7. Smoking and tobacco use
	8. Intentional childhood injuries
6.Injury……...	9. Unintentional childhood injuries
	10.Overweight and at risk for overweight
7.Child care	
8.Family and parenting	
9.CSHCN systems of care	
10.Early prenatal care	

Issues surrounding health in child care are addressed through the State Performance Measures on mental health (for young children), access to health insurance and access to health care coverage, and unintentional injuries. Family and parenting issues are addressed through the State Performance Measures on mental health (for young children), medical home for all, and health insurance and access to health care. CSHCN systems of care is included in the State Performance Measures on mental health (for young children), medical home for all, dental health including CSHCN, and health insurance and access to health care. Early prenatal care has been incorporated into our new State Performance Measure on disparities in birth outcomes. Also not surprising, is that several of Wisconsin's top ten needs today differ from the needs identified five years ago.

Strengths and Weaknesses of the Comprehensive Needs Assessment Process

The most obvious strength of the comprehensive needs assessment process was the previous work and extensive datasets and state health priorities developed for the *Healthiest Wisconsin 2010.* When available, staff used this data and information to define the needs in the state. In addition, staff defined more specific needs related to infant birth weight, and infant mortality not currently included as indicators in *Healthiest Wisconsin 2010.*

A second strength was the expertise and investment contributed by the diverse partners and stakeholders. The Listening Sessions provided a format for defining the needs of the community. The Q-Sort process meetings required achieving consensus and rich qualitative discussions occurred. Again, the results from both procedures were very similar.

An apparent weakness was failing to get more stakeholders to participate in the Q-Sort process. We contacted 175 letters, received 90 responses from people voicing interest in participating, but only 65 people completed the process. We should have done more outreach to get the remaining 25 people (who had voiced an interest in doing the Q-Sort process) to participate in the process. However, we received public comments from 46 different individuals through our website. When added to the 65 respondents we had input from over 100 interested individuals throughout Wisconsin. Website readers were asked to respond to four different questions: 1) What are your suggested "Top 10" problems/needs from the top 20 needs/problems list; 2) Do you have suggestions for a specific performance measures to address these needs (e.g. percent of women who use tobacco during pregnancy); 3) Please list any other comments; and 4) Please select from the list which best describes you. In addition, this method of soliciting public comments on a random basis resulted in a strikingly similar listing of priority needs as that produced from the targeted Q-Sort process.

Local health departments are required by Wisconsin statute to conduct a local needs assessment. This data and information was useful throughout the needs assessment process; however, at times the extra work of another needs assessment (i.e., Title V) may have influenced LHDs lack of participation in the formal Title V Needs Assessment process. Therefore, although we had hoped for more local health department participation in the formal Q-Sort process, a clear majority of comments through this web-based public input process were from local health departments (65%), followed by health professionals (15%), community-based organizations (13%), and other interested citizens (7%).

> Another weakness in the process was a result of the lack of quantitative data for some of the emerging needs. This was further complicated because the 44 needs were not always comparative. Some of the 44 needs represented critical health outcomes and leading health indicators, as well as, behaviors or interventions that substantially contribute to important health outcomes. For example, one of the 44 identified needs was child passenger safety which is really an <u>intervention</u> for the health indicator related to motor vehicle deaths and hospitalizations.

<u>Wisconsin's Top 10 Needs and Related Activities</u>

Approximately 40% of Wisconsin's Title V funds are distributed to local agencies and organizations (including tribes) on an annual basis through the Division of Public Health's performance-based contracting process. The purpose of performance-based contracting is to help agencies focus on improving health status and health outcomes for Wisconsin's citizens. Performance-based contracting is a non-competitive process and LHDs have the "first right of refusal" to the allocated funds.

Every fall, the Division of Public Health initiates a three-way negotiation process with representatives from the LHDs, the DPH regional office staff, and the DPH central office staff.

To make the negotiation process easier, LHDs may (but are not required to) select from a list of template objectives developed specifically by the MCH/CSHCN Program that align with Wisconsin's priority needs for the maternal and child health population. (Template objectives are "pre-approved" activities and, as a result, streamline the negotiation process.)

In 2004, the MCH/CSHCN Program had developed 13 template objectives addressing the following topics: pregnancy and healthy outcomes; comprehensive physical exams for uninsured or underinsured children; child passenger safety; home safety assessments; prevention and intervention for early childhood dental caries; newborn home visitation; health education activities; nutrition coalition building; and breastfeeding promotion *(see Attachment C - Year 2005 Template Objectives for Maternal and Child Health Program)*.

If LHDs do not select a template objective(s), then they must create a separate, distinct objective(s) that meets the needs of the maternal and child health population within their jurisdiction. In addition, the objective must be deemed as an acceptable activity by the MCH/CSHCN Program.

We will use the findings from the 2005 needs assessment (including our newly created State Performance Measures) to develop new and/or revise current template objectives. Negotiations for these activities will begin in the fall of 2005 for start up January 1, 2006.

Resource Allocation

Wisconsin has a long-standing history of releasing the majority of Title V funds for use at the local level. Overall, 60% of Wisconsin's Title V funds are distributed to local, regional, and statewide agencies annually. As previously indicated, almost 40% of the Title V funds are released through the DPH's non-competitive, performance-based contracting process. The MCH/CSHCN formula allocation for performance based contracting was developed in 2000 based on the following criteria:

- Providing a base allocation for each health department based on their level of functioning according to public health statute, i.e., Level 1, 2 or 3,
- General population (ages 0 – 44) within the LHDs jurisdiction; the target population defined as children 0 - 17 at < 150% FPL and females 18 – 44 at <185 % FPL within the LHDs jurisdiction,
- Risk factors defined as infant deaths, mothers <high school education, and low birth weight within the LHDs jurisdiction, and
- Square mileage of the geographic area for the purpose of addressing rural needs.

Allocations are adjusted as more current data becomes available.

The remaining Title V funds (approximately 20%) are released on a competitive basis approximately every 5 years. During the spring (of 2005) we embarked on a new competitive process with statewide program activities scheduled to begin July 1, 2005 through December 31, 2010. The five statewide projects will address services to: improve infant health and reduce disparities in infant mortality; support a genetics system of care; improve child health and prevent childhood injury and death; improve maternal health and maternal care; and create a

parent to parent matching program for families with CSHCN. These topic areas were selected based on what we learned during our 2004 Listening Sessions where we asked over 350 participants: "What particular issues/needs should statewide projects focus on in 2005-2009?"

Monitoring Progress

Inherent in performance-based contracting is the ability to measure progress accomplished on each objective at six months and at the end of the year. During the three-way negotiation process all parties agree on the objective and accompanying "tangible deliverable". A mid-year review is conducted to: evaluate the agency's progress on meeting the objective(s); what difficulties may be arising; and what technical assistance, if any, is needed. The end-of-the-year review evaluates if the deliverable has been met and requires supporting documentation as evidence. If an objective is not met the DPH initiates an accountability clause.

Data Collection

During FFY 2003, the existing MCH and Family Planning/Reproductive Health Data Systems were replaced with a state-of-the-art web-based application called Secure Public Health Electronic Record Environment (SPHERE) and was released statewide for users in August of 2003. SPHERE is used for collecting data for Maternal and Child Health (MCH), Children with Special Health Care Needs (CSHCN), and Family Planning/Reproductive Health (FP/RH). All agencies funded with Title V dollars that provide services to MCH and CSHCN populations are required to use SPHERE. Several FP/RH projects also use SPHERE but are not required if they have a system to provide the required data/information.

SPHERE was developed by the Department of Information Technology (DoIT) at the University of Wisconsin-Madison for the DPH in cooperation with LHDs, tribal agencies, and private non-profit agencies. Protecting the privacy and rights of clients and the security of information contained in SPHERE was a high priority for the DHFS, DPH. Access to SPHERE is limited to public health authorities and their authorized agents who have signed a Confidentiality and Security Agreement. Demographic (non-health information) is shared in a statewide registry database. All health information is maintained in a secure local organization database. Breach of confidentiality will result in removal of user's access and may result in penalties for improper disclosure of health information.

SPHERE is designed as a comprehensive public health system to document and evaluate public health activities and interventions at the individual, household, community, and system level. SPHERE interventions are actions taken on behalf of communities, systems, individuals, and families to improve or protect health status. The interventions include: Surveillance; Disease and other Health Event Investigation; Outreach; Case-Finding; Screening; Referral and Follow-up; Case Management; Delegated Functions; Health Teaching; Counseling; Consultation; Collaboration; Coalition Building; Community Organizing; Advocacy; Social Marketing; Policy Development; and Policy Enforcement. SPHERE public health activities and interventions help document and provide measurements related to Maternal and Child Health, Children with Special Health Care Needs, and Family Planning/Reproductive Health. There are currently 1,154 active SPHERE users representing 145 organizations including all local health

departments, Regional CSHCN Centers, private-not-for profit agencies, and the majority of the tribes. These organizations utilize SPHERE to document MCH, Reproductive Health, and CSHCN services provided to individuals, households, communities, and systems. The total number of SPHERE unduplicated clients is 150,352. In 2004 (January 1, 2004 - December 31, 2004) SPHERE was used to document 46,964 unduplicated Individual/Household Public Health Activities and 12,222 Community and System Public Health Activities as defined in the following table.

SPHERE: INTERVENTION	Unduplicated Clients*		Activities*		Community / System Activities*
	#	%	#	%	#
Advocacy	570	1.2	1,108	0.7	12,673
Case Finding	635	1.4	678	0.4	117
Case Management	15,107	32.2	46,222	27.4	115
Coalition Building	36	0.1	40	0.0	1,169
Collaboration	555	1.2	1,005	0.6	1,282
Community Organizing	N/A	0.0	N/A	0.0	280
Consultation	1,588	3.4	2,146	1.3	3810
Counseling	1,820	3.9	4,585	2.7	242
Delegated Functions	11,627	24.8	25,477	15.1	540
Disease and Health Event Investigation	2,581	5.5	4,473	2.6	1,906
Health Teaching	13,112	27.9	27,030	16.0	3,143
Outreach	957	2.0	4,012	2.4	436
Policy Development	N/A				1,198
Policy Enforcement	N/A				1,207
Referral and Follow-up	9,299	19.8	17,253	10.2	471
Screening	21,016	44.7	32,624	19.3	265
Social Marketing	N/A				209
Surveillance	1,098	2.3	1,974	1.2	542

* Data reported in SPHERE does not represent statewide activities for 2004.

The DPH collaborated with the Bureau of Health Information (BHI), Vital Records to develop and implement a Birth Record Delivery project. SPHERE was determined to be the most efficient and secure method for LHDs to receive electronic birth records. An Initiation Report for the SPHERE Birth Data Delivery project was developed. SPHERE serves as the mechanism for LHDs to receive confidential birth record reports for all infants whose mother resided in their jurisdiction. Prior to providing these records electronically in SPHERE, the LHDs received paper copies of the birth record reports. Birth record data was imported into SPHERE so that it was available to the appropriate local public health jurisdiction. Leveraging the existing security infrastructure of SPHERE ensured that access to birth record data was restricted to only those individuals with assigned permissions and only those records for their particular jurisdiction.

In 2005, a governance structure for the DPH, Public Health Information Network (PHIN) was established. It is designed to provide the infrastructure for improved MCH access to program

relevant information and data and improved data linkages. PHIN consolidates multiple systems into one initiative using a common set of functions. PHIN is the platform for integrated public health data in Wisconsin. The PHIN acts as a portal into applications supporting public health in Wisconsin. Five PHIN Program Management Workgroups have been established:
1) Administration, 2) Security, 3) Communications, 4) Process Improvement, and 5) Portal. The SPHERE Administrator serves on the PHIN Program Management Committee and the Security and Administration Workgroups. Integration has positive effects on sustainability. It allows for cost sharing for upgrades and maintenance contracts, capability to measure outcomes against MCH/CSHCN program objectives, role-based access to reports generated for stakeholders, administrative investment, and continued funding opportunities.

A Blue Cross/Blue Shield proposal was prepared to develop a Program Application Module (PAM) for electronic billing and to collect data using personal digital technologies. Although this grant was not funded, work is being done on a Discovery & Initiation Report for an electronic billing PAM to provide a direct electronic format for submitting Medicaid billing information. It is considered a high priority and the specifications will be written in 2005 and implemented in 2006 if funding is secured for the project. The new statewide WIC web-based application will be implemented in fall 2005. SPHERE will also have data sharing capabilities with this new web-based application. Initiatives planned for 2006 include SPHERE enhancements, transfer of data from WIC into SPHERE, additional birth record reports, and development of lab messaging in SPHERE.

Wisconsin's Needs Assessment Results, National Performance Measures, Health Status Indicators, and Health Capacity Indicators

The relationship of each of these measurements clearly defines the role of Title V in Wisconsin and the challenges we face in the 21st century. The ten Wisconsin priority needs will shape our future direction and activities, and guide allocation decisions over the next five years.

- Relationship of Wisconsin's 10 priority needs to National Performance Measures

Ten National Performance Measures align to 9 of Wisconsin's 10 needs; smoking and tobacco use is the only need that is not linked to an NPM. Those NPMs that are not covered by Wisconsin's 10 needs address CSHCN, newborn hearing screening and immunizations among young children.

- Relationship of Wisconsin's 10 priority needs to Health System Capacity Indicators

Seven (of the 9) Health System Capacity Indicators link to 7 of Wisconsin's 10 needs. Wisconsin's three needs that do not align with a Health System Capacity Indicator are:

- Intentional childhood injuries,
- Unintentional childhood injuries, and
- Overweight, obesity and lack of physical activity.

Wisconsin's data for HSCI #09A (reporting and tracking form) show that we have excellent data capacity for reporting on overweight and at risk of overweight for high school youth from the

Youth Risk Behavior Survey (YRBS) and for the WIC population (children 0-4) from the Pediatric Nutrition Surveillance System (PedNSS).

- Relationship of Wisconsin's 10 priority needs to Health Status Indicators

All 12 Health Status Indicators link to 9 of Wisconsin's 10 needs; the only need that is not linked to a Health Status Indicator is overweight and at risk of overweight.

The following table shows the relationship of the Wisconsin's 10 needs to the National Performance Measures, Health Capacity Indicators, and Health Status Indicators. Clearly, the Title V data indicators link to our needs assessments results as every need has at least one corresponding data indicator related to Title V reporting. In addition, the links and relationships to the other principal state initiatives *(Healthiest Wisconsin 2010* and *KidsFirst)* are strong and assure collaboration and partnerships amongst our stakeholders.

Wisconsin's Top 10 Needs	National Performance Measures	Health Systems Capacity Indicators	Health Status Indicators
1.Disparities in Birth Outcomes • Infant mortality • LBW • Preterm • Early Prenatal care	Percent VLBW Percent VLBW delivered at facilities for high risk First trimester prenatal care	Rate of children less than 5 years of age hospitalized for asthma Percent of SCHIP enrollees whose age is less than one year who received at least one periodic screen. Percent of women (15 through 44) observed to expected prenatal visits are greater than or equal to 89 percent	Percent of live births less than 2500 grams Percent of live singleton births less than 2500 grams Percent of live births less than 1500 grams Percent of live singleton births less than 1500 grams Demographics
2. Contraceptive Services • Unintended pregnancy • Teen births • Abstinence from adolescent sexual activity	Rate of births among teenagers 15 – 17		Rate of women 15 –19 with chlamydia Rate of women 20 – 44 with chlamydia
3. Mental Health for All	Rate of deaths from suicide among 15 – 19		
4. Medical Home for All	CSHCN receive care within a medical home	Percent of SSI beneficiaries receiving rehabilitation services	
5. Dental Health (including CSHCN, racial/ethnic, linguistic, and geography, income)	Percent of third graders who received protective sealants	Percent of ESPDT / MA eligible children who have received dental services	
6. Health Insurance and Access to Health Care	Percent of children without health insurance	Percent of MA enrollees under 1 year who receive at least 1 periodic visit	
7. Smoking and Tobacco Use • Youth • Pregnant Women		Data capacity	
8. Intentional childhood Injuries • Child Abuse and Neglect	Rate of deaths from suicide among 15 – 19		
9. Unintentional Childhood Injuries	Rate of deaths to children 14 years and younger from motor vehicle crashes		Death rate for children <14 due to unintentional injury. Rate of motor vehicle crashes among 15-24 Death rate for 15-24 for unintentional injuries. Rate of non-fatal injuries among children under 14. Rate of non-fatal injuries among 15-24
10. Overweight and At Risk for Overweight	Percent of mothers who breastfeed their infants at hospital discharge		

Other Related Needs Assessments

Wisconsin Adolescent Health System Capacity Assessment Action Plan - In the spring of 2004, Wisconsin was one of three states selected by the Association of Maternal and Child Health Programs (AMCHP) - Annie E. Casey Foundation to participate in a pilot Adolescent Health System Capacity Assessment. The purpose of this pilot was to examine the Division of Public Health's commitment to adolescent health (internally) by examining components such as partnerships, planning and evaluation, policy and advocacy, surveillance/data system, and technical assistance. Ultimately, AMCHP's goal was to complete a System Capacity Public Health Improvement Tool for Adolescent Health. Working over a two and half-day period, state MCH staff and our partners determined that our three top priorities were: youth/family partnerships; a commitment to adolescent health, and the importance of adolescent surveillance and data systems.

To actualize these priorities, Wisconsin's MCH/CSHCN Program embraced the new 2005 CDC-Health Resources and Services Administration's (HRSA): *A Guide to for States and Communities to Improve the Health of Adolescents and Young Adults.* The overall goal of this initiative is to help state and local agencies and organizations build successful adolescent health programs utilizing effective "how to" approaches, case studies, practical tools, data, and federal resource linkages. Additionally, this Guide encompasses 21 Critical Health Objectives for adolescents and young adults age 10 to 24 years old. These components include the areas of mortality, unintentional injury, violence, substance abuse and mental health, reproductive health, and prevention of chronic disease into adulthood.

By connecting both our adolescent health capacity pilot priorities and the new adolescent and young adult guide, Wisconsin will increase the integration and coordination of adolescent health-related programs within DHFS and increase the capacity of local health departments, local school districts, and community-based organizations to more effectively address adolescent health.

Early Childhood Comprehensive System - Of the five ECCS components, three of them align with Wisconsin's corresponding priority needs: access to health care for children; health insurance coverage; and child abuse and neglect. In addition, data obtained from key informant interviews and focus groups conducted as part of an environmental scan during the past year of planning for ECCS found that there was a need for better coordination of services that exist so parents are assisted with finding the services their children need. Plans for ECCS in 2005 – 2006 are to finalize, distribute, and incorporate findings from the environmental scan with particular focus in the Milwaukee area.

Oral Health - In Wisconsin, tooth decay is the most common chronic childhood disease – five times more prevalent than asthma. Only one in four children enrolled in Medicaid receives any dental care. According to the DHFS's *Make Your Smile Count* Survey, about 30 % of Wisconsin third-graders have untreated tooth decay and 4% needed urgent care. According to the DHFS's *Healthy Smiles for a Head Start* data report, 24 % of children (3 to 6 years of age) in surveyed Head Start programs had untreated decay.

In addition, a significantly higher proportion of minority children had untreated decay. Twenty-five percent of white children screened had untreated decay compared to 50% of African American, 45% of Asian, and 64 % of American Indian children. Also, children attending lower income schools had significantly more untreated decay (44.5%) compared to middle income (31.7 %) and higher income schools (16.6 %).

B.2 Needs Assessment Partnership Building and Collaboration

B2 (a) Building and enhancing collaboration with other HRSA programs

The primary methods used to build and enhance partnerships between the Title V Program and other HRSA programs require: program awareness, understanding the benefits for collaboration, and making the effort for regular communication through meetings, sharing of materials, and participation on specific work activities that will, ultimately, benefit Wisconsin's citizens. The following HRSA programs that will be addressed are: Primary Care, Emergency Medical Services for Children, Early Hearing and Detection Intervention, Preparedness, Healthy Start Initiatives, Trauma, and Brain Injury.

Primary Care - The Bureau of Local Health Support and Emergency Medical Services within the Division of Public Health is responsible for overseeing primary health care programs, including the Primary Care Cooperative Agreement, the Health Professional Shortage Areas (HPSA) designation program, federal National Health Service Corps (NHSC) program, and the Health Care for the Homeless program. The Bureau of Community Health Promotion works closely with the Bureau of Local Health Support and Emergency Medical Services.

Emergency Medical Services for Children - EMSC works within the Injury Prevention Program to assure that emergency care for children – from injury prevention through rescue and rehabilitation – meets the growth and developmental needs of children. To support preparation for children and families who live with specific technical and physical needs that may impact responders in an emergency, the EMSC program works in conjunction with the MCH/CSHCN Program. For children with special health care needs, a program called *Child Alert*, has grown. The *Child Alert* Program facilitates communication between local emergency medical services and families of children with special needs to promote effective response to an emergency that encompasses the child's individual technical and physical needs. EMSC has a role in providing the children's focus in preparedness and bioterrorism activity. It also works to address specific needs of children involved in trauma and brain injury by collaborating with other HRSA funded initiatives. The Title V MCH/CSHCN Program is aware of the proposed National EMSC Performance Measures.

Early Hearing Detection and Intervention (EHDI) - In September 2004, a reorganization of the Division of Public Health was approved. This reorganization strategically places the EHDI program called Wisconsin Sound Beginnings (WSB) in the Family Health Section. A new team was created called "Early Screening" and includes Genetics Services, the Congenital Disorders Screening Program, and the WSB Program including the EHDI data collection and tracking project called WE-TRAC. Programmatically team members report to the CSHCN Medical Director and are supervised directly by the FHS Supervisor. Other programs within this section include the Title V MCH and CSHCN Programs and the Birth Defects Surveillance Program.

The Early Screening organization and management structure was created to positively impact data collection efforts as well as the coordination and integration of the screening/surveillance programs (hearing, metabolic, and birth defects) with support and services (genetic services, Title V funded Regional CSHCN Centers, Wisconsin Medical Home Learning Collaborative). The six CSHCN core outcomes provide a framework that guides all the Early Screening Team activities.

Healthy Start Initiatives - MCH/CSHCN staff participate in national Healthy Start meetings and local advisory meetings with the Milwaukee Healthy Beginnings Project of the Black Health Coalition and the Honoring Our Children Project of Great Lakes Inter-Tribal Council. The Healthy Start projects are key partners of a Healthy Babies initiative to identify new approaches to improve birth outcomes and reduce disparities. Collaborative efforts support a Native American Healthy Babies Action Team that meets prior to the annual DHFS-Wisconsin Indian Tribes Conference. A Racial and Ethnic Disparities in Birth Outcomes Action Team Meeting focused on disparate African American infant mortality rates. In addition, Title V program staff provide consultation services to GLITC on the Medicaid Prenatal Care Coordination benefit and actively participate in the Milwaukee Fetal Infant Mortality Review Program funded by the Milwaukee Healthy Beginnings Project. Recommendations from the Milwaukee FIMR are included in activities for two MCH-funded statewide projects.

Trauma - Wisconsin is in the process of implementing a statewide trauma care system under the leadership of the Emergency Medical Services. Injury prevention is one of the key components to any trauma system. During the development of the trauma system plan for Wisconsin, there were multiple subcommittees including Injury Prevention. Representatives from the Injury Prevention community were brought together to assist in the development of this portion of the Plan and have continued to remain involved with the ongoing planning and implementation of the statewide trauma system along with other partners such as EMS providers, hospital staff (administrators, MDs, RNs), law enforcement, local health departments, academia, and educators.

Brain Injury - The Injury Prevention Program is a member of the statewide Traumatic Brain Association of Wisconsin - Advisory Board. A restructuring within the Advisory Board created a Prevention Subcommittee that includes representation from the Injury Prevention Program. The focus on primary prevention of traumatic brain injuries has become one of the Board's priorities. Traumatic brain injuries are included in the injury data currently being collected within the Injury Prevention Program because of the number of injuries from falls, motor vehicle related crashes, and violence that result in brain injury related hospitalizations and deaths in Wisconsin.

Oral Health - The State Dental Hygiene Officer in the Bureau of Health Information and Policy coordinates and monitors oral health grant programs managed by local health departments and tribes for fluoride mouth rinse, fluoride supplement, fluoride varnish, surveillance, community water fluoridation and dental sealants. Regional oral health consultants are contracted through a Health Resources Services Administration grant to provide training to primary health care

providers on integrating preventive oral health measures into healthcare practice with oversight from the State Dental Hygiene Officer. The Chief Dental Officer is the principle advisor.

B2 (b) Building and enhancing collaborations with state agencies and programs

Wisconsin's Title V staff have numerous collaborations and connections within the Department and Division, as well as with other state agencies. The program focus drives the collaborations such as birth defects, family planning, teen pregnancy prevention, child abuse and neglect, tobacco prevention and cessation, injury prevention, lead, EHDI, CSHCN, autism, and women's health, for example.

Department of Health and Family Services Programs

Public Health Council - The Public Health Council was created by 2003 Wisconsin Act 186. By statute, the Council's purpose is to advise the DHFS, the Governor, the Legislature, and the public on progress in implementing the state's 10-year public health plan and coordination of responses to public health emergencies. The 23 members of the Council were appointed by Governor Jim Doyle and met for the first time in October 2004. Detailed information can be found at www.publichealthcouncil.dhfs.wi.gov/. Meetings are held every other month.

Council on Birth Defect Prevention and Surveillance - Wisconsin Stature 253.12 requires that a Council on Birth Defect Prevention and Surveillance be maintained by the Department and meet at least four times per year. The council members are appointed by the Secretary of the Department of Health and Family Services and serve four-year terms. They represent a number of interested parties and contribute much expertise. The council is charged with performing four tasks. We have a CSHCN health educator staff the Council.

- Make recommendations to DHFS regarding the establishment of a registry documenting children with birth defects diagnosed or treated in Wisconsin, and regarding the rules about what birth defects should be reported, the format for reporting, and the procedures for reporting.
- Coordinate with the Early Intervention Inter-Agency Coordinating Council to facilitate the delivery of early intervention services to children from birth to three with developmental needs.
- Report every two years about the effectiveness, utilization and progress of the registry.

Family Planning Council - The Department of Health and Family Services established a Family Planning Council in 2004. The purpose of the council is to provide advice to the Secretary and foster internal Departmental coordination to insure access to cost-effective family planning services and reproductive health care. Goals which the Family Planning Council is to focus upon are to: ■ Provide access to affordable reproductive health care, especially to low-income women; ■ Help prevent unintended pregnancies; and ■ Deliver cost-effective services through a network of viable, coordinated providers. A health educator provides technical assistance to the Council.

Governor's Task Force on Oral Health Access - As part of the *KidsFirst Initiative,* Governor Doyle directed his office to create the task force and to develop policy recommendations on the following issues:

1. Educating an adequate number of dental health professionals.
2. How communities and the state might better recruit and retain dental professionals throughout Wisconsin.
3. Improving access to dental care for children in Medicaid and BadgerCare.
4. Improving access for all children and to provide better preventive dental care.
5. Most effective ways to spend Medicaid dollars on preventive care.

This Task Force began meeting in October 2004. The Governor's Task Force on Oral Health Access submitted a final report with thirty-one recommendations in June of 2005. Division of Public Health staff, including the Chief Dental Officer and State Dental Hygiene Officer (funded by the MCH Block grant), along with staff from the Office of Strategic Finance and the Division of Health Care Financing offered technical assistance to the Task Force.

The Department of Health and Family Services prioritized oral disease prevention measures in the 2005-2007 Department budget, most notably the Healthy Smiles for Wisconsin Seal a Smile Program. The State Dental Hygiene Officer and the Chief Dental Officer in the Division of Public Health assisted the Department in developing oral health budget requests.

Mental Health Leadership Team - As a part of the Governor's *KidsFirst Initiative* goal to support the Infant Mental Health Plan for Wisconsin's citizens, the Department of Health and Family Services (DPH, DCFS, DHCF, DDES, OSF) has assembled a Leadership Team to spearhead a Department Infant Mental Health Action Plan. The Leadership Team will develop the plan that will identify ways that DHFS can weave infant mental health best practices and principles into the Department's programs and services in order to promote healthy child development and promote prevention, early intervention and treatment. Several Title V FHS staff participate in this initiative.

Abstinence/HIV/STD/Teen Pregnancy Prevention - The Department of Health and Family Services is in its third year with the Center for Disease Control's Department of Public Instruction sub-grant to improve the coordination, communication and collaboration of state and local leaders and community providers. The FHS Comprehensive School Health Program Director provides the Department's leadership.

Historically, these groups have operated in silos but the purpose of this grant is to break that approach. Building from the Comprehensive School Health Program's structure, this grant is also a joint partnership between DHFS and DPI. Deliverables to date have included: successful a networking and capacity building events for Abstinence, HIV, STD and Teen Pregnancy Prevention state and local community provider participants. Plans for the 2005-2006 include: developing network communication system; hosting ten youth listening sessions in urban, rural and Tribal communities; and a central website for all data related to youth sexual risk behavior such as STIs, HIV/AIDS, pregnancies, births and those associated with our state's Youth Risk Behavior Survey.

Division of Public Health Programs

Statewide Poison Control System - The Statewide Poison Control System was implemented on July 1, 1994, with state GPR funds ($375,000) and a 50% match requirement from each regional poison control center. The program provides Wisconsin citizens with the following services: a toll-free hotline allowing easy access for poison control information; quality interpretation of poison information and needed intervention; and education materials for consumers and professionals. As of July 1, 2001, the Wisconsin Poison System contract solely supports the poison control center located at the Children's Hospital of Wisconsin (CHW), Milwaukee.

In February 2005, the center received full certification by the American Association of Poison Control Centers (AAPCC). The AAPCC is the national organization that sets standards and collects exposure data for poison centers across the country. The process of obtaining certification status has taken several years because it required building an independent center at CHW, and recruiting and developing staff to answer calls 24 hours a day, 365 days per year. Criteria for center certification designates only registered nurses, licensed pharmacists or other top-level health care professionals as certified poison information specialists. In addition, medical leadership must be provided by board certified toxicologists, and a center must meet rigorous standards of quality before it is considered. This new certification makes the Poison Center the first in Wisconsin history to become nationally certified. The University of Wisconsin Hospital and Clinics, Madison continues to support the poison control system in Wisconsin by staffing a Poison Prevention Education Center. The Children's Hospital of Wisconsin Poison Center received 64,836 total calls during CY 2004; 43,718 were human exposure calls.

Integration of Chronic Disease Across the Life Span - Recently, the Title V Program has joined the DPH Program Integration Workgroup. This workgroup meets every other week to discuss and plan coordination and integration of chronic disease programs. This committee will be an important link for focusing on MCH population issues across the lifespan.

Tobacco - Reduction of tobacco use efforts continue through Wisconsin's Tobacco Prevention and Control Program, First Breath Prenatal Smoking Cessation Program and MCH-funded perinatal care coordination. The feasibility of developing a marketing campaign for providers regarding the Medicaid benefit covering tobacco cessation is being examined by DPH and DHCF. In addition, DPH is exploring with DHCF the option of expanding Medicaid coverage and securing federal match for several program activities. A health educator is active in this initiative.

Childhood Immunizations - Currently various collaborations exist among state agencies and programs related to assuring children in Wisconsin are immunized. All local health departments provide immunizations to persons in their jurisdiction with funding from the Wisconsin Immunization Program. They can now access electronically, immunization data from the Wisconsin Immunization Registry (WIR). Some local health departments work directly with child care agencies and schools to monitor immunization services of children by referring those children needing immunizations to appropriate resources and use Title V funds in the consolidated contracting process.

There is coordination with the WIC Program and the Immunization Program involving all of the WIC providers enrolled in the WIR. The Wisconsin Immunization Program cost shares with WIC to conduct immunization assessments and refers at WIC voucher pick-up. Statewide tracking of children at age two, enrolled in Medicaid- Population-Based Services, including children with special health care needs (CSHCN), is currently done.

Emergency Medical Services for Children (EMSC) and Injury Prevention - EMSC and injury prevention focus on identifying the major causes of injury morbidity and mortality across the life-span. One very important initiative that the local health departments have built is the home visitation program. Local public health staff, primarily nurses, have for many years initiated home visits for newborns, families with CSHCN, and other at risk populations. Incorporating a home safety evaluation into these visits has helped to promote injury prevention (such as falls, burns, poisoning) as well as education for the parent that describes how normal growth and development activities can place a child at risk for injury. The WIC program has also been a prime location for placing injury prevention materials and information for families to view/pick-up when they come in for their certification or vouchers.

Childhood Lead - The Wisconsin Lead Poisoning Prevention Program (WCLPPP) initiated a partnership with the WIC program to fund the collection of blood samples for lead tests from children when they have their hematocrit or hemoglobin drawn. The WIC population is at high-risk for lead poisoning due to the predominance of old housing in Wisconsin, and the availability/affordability of lead-safe housing for low income families. Currently, WCLPPP directs federal CDC funds to local WIC agencies for blood lead testing, and distributes state funding to local health departments who also utilize their WIC agencies for testing. The WCLPPP has also developed a home visitation protocol that assists public health professionals visiting a home to identify lead hazards, inform the property owner and/or resident, and provide both with information on strategies to decrease children's exposure to lead. Funding for this project is often used to implement the protocol via expansion of the local Prenatal Care Coordination or Newborn Visitation Program.

Asthma - Asthma is a public health priority for Wisconsin, as indicated by the national health plan, Healthy People 2010, and the Implementation Plan of the state public health plan, Healthiest Wisconsin 2010. In 2001, the Wisconsin Department of Health and Family Services (DHFS) created the Wisconsin Asthma Coalition (WAC). DHFS began working with its partners, including the Children's Health Alliance of Wisconsin, to bring together asthma stakeholders from around the state to form the WAC to develop a comprehensive state asthma plan. The Department successfully applied for funds from the U.S. Centers for Disease Control and Prevention (CDC) to support the creation of an asthma coalition and a statewide asthma plan.

The WAC created and published the "State of Wisconsin Asthma Plan" in October 2003. The Asthma Plan has been received favorably throughout the state, and membership within the coalition continues to grow. The overarching goals of the Asthma Plan are to: 1) Expand and improve the quality of asthma education, prevention, management and services, and 2) Decrease the disproportionate burden of asthma in racial or ethnic minority and low-income populations.

The implementation efforts currently underway are:

1) Working with local asthma coalitions across the state,
2) Providing mini-grants for various local coalition activities and the creation of new local coalitions,
3) Support of the Allergist Outreach Education to Primary Care Practices,
4) Low-sulfur fuel program, and
5) Work-related asthma diagnosis guidelines and health history data collection instrument.

Diabetes - In 2001, the CSHCN Program and the Diabetes Prevention and Control Program combined efforts to coordinate a statewide effort to develop, design, distribute and implement a resource guide for schools and families regarding care of children with diabetes while in school. In 2002, this resource guide, *Children with Diabetes: A Resource Guide for Wisconsin Schools and Families* was published. The purpose is to help those working with children who have diabetes understand the disease, basic diabetes care requirements, legal issues, and most importantly, their own personal role. The Diabetes Prevention and Control Program, in collaboration with the Department of Public Instruction, distributed the manual as well as conducted training sessions directed at school staff, on the effective use of the manual within the school environment. Copies of the manual are available from the Wisconsin Division of Public Health, Diabetes Prevention and Control Program website: www.dhfs.wisconsin.gov/health/diabetes/Cons_resources.htm .

Statewide Systems Development Initiative - The SSDI Program coordinates with multiple programs to promotion data integration and data linking. The program works closely with the Office of Vital Records to integrate birth record data into SHPERE and with the WIC programs to link WIC and MCH data. Program data integration is a cross cutting issue for the Public Health Information Network (PHIN) and local health departments. The PHIN is designed to provide the infrastructure for improved maternal and child health access to program relevant information including data and improved data linkages. The FHS houses the SSDI program director to assure collaboration across the section and bureau.

Nutrition and Physical Activity - The Nutrition and Physical Activity Section contains several programs that collaborate with the MCH/CSHCN Program and its initiatives. These programs include the WIC Program, Farmer's Market Nutrition Program, Commodity Supplemental Food Program, the Emergency Food Assistance Program, 5 A Day Program, and the Nutrition and Physical Activity Program. The Nutrition and Physical Activity Section programs have collaborated with the MCH/CSHCN Program to include nutrition-related objectives in the performance-based contracting process and have served as a technical resource to MCH staff. Section staff also routinely includes information in the quarterly MCH/CSHCN update. The Nutrition and Physical Activity Program has been developing a state plan for obesity prevention and MCH (central and regional office) staff have participated in this planning effort. The Wisconsin Breastfeeding Coalition is co-chaired by the WIC Breastfeeding Coordinator/ Nutritionist and is an integral part of efforts to meet the MCH national performance measures. WIC and MCH staff collaborated in 2003 – 2004 to write and implement a USDA Special Projects grant to determine best practices and barriers serving low income women in both WIC and Prenatal Care Coordination (a Medicaid Program benefit). And, of the ten DPH Regional Office Nutrition Consultants, six are jointly funded by WIC and Title V, and some other sources

of funding. They assure collaboration between WIC and MCH at the local level, including via the provision of trainings. One of these consultants has been collaborating with the CSHCN Program, WIC, and Medicaid staff to address the improvement of nutrition services for children with special health care needs through Medicaid reimbursement.

Preparedness – The MCH/CSHCN Program continues to be involved with the CDC and HRSA-funded Preparedness Activities for Wisconsin. MCH Program staff serve as members of the "Community Coalition Steering Committee", a preparedness initiative that defines a comprehensive definition of special populations, including children with special health needs. A supporting checklist for human services providers, local health departments, hospitals, as well as special populations has been developed. Four Wisconsin focus groups in special population communities (defined as elderly; CSHCN; those with cognitive delays, emotional and economic vulnerability; and mental illness) were conducted to gain input regarding their emergency needs. The MCH Medical Director has been actively engaged in the strategic planning and priority setting for the 2006 Preparedness grant.

Abstinence - Although Wisconsin's Abstinence Education Program is funded by a grant from the Administration on Children, Youth, and Families in the U.S. Department of Health and Human Services, it is located within Wisconsin's Division of Public Health.

The Abstinence Program collaborates closely with the Adolescent Pregnancy Prevention Coalition to integrate the message of sexual abstinence into all DHFS adolescent health related programs. Collaboration partners represent all areas of the state. DHFS program partners include Youth Policy, Preconception/Reproductive Family Health, Sexually Transmitted Disease Control, and HIV/AIDS Control. Program partners work together achieve the State Plan to Prevent Adolescent Pregnancy goal of increasing the number of adolescents choosing sexual abstinence.

Oral Health - The Chief Dental Officer in the BCHP and the State Dental Hygiene Officer in the Bureau of Health Information and Policy collaborated with the Bureau of Communicable Disease and Preparedness Refugee Health Program to integrate oral screening into the medical screening record, offered training to physicians and nurses willing to incorporate oral screening into their physical assessments, and secured dental referral sources to better meet refugee needs. Data is now being disseminated that show 39.9% (798) of the Hmong refugees received a dental screening and of those, 78% (626) had dental caries.

Early Childhood Comprehensive System - During the past 18 months of MCH leadership in initiating the ECCS project, a shift toward greater communication has evolved among stakeholders from the five component areas, with a growing interest in systems integration for young children and their families. One example: the ECCS project is usually no longer referred to as "that MCH grant that deals with health", but as "the early childhood comprehensive (lower case) *system development* initiative" to which many are making contributions. An MCH goal for the ECCS project is that it continues to be viewed as *the* statewide comprehensive early childhood systems development project - one that puts a priority on and welcomes collaborative engagement among all early childhood component leaders. In preparation for our submission of the ECCS implementation plan, currently scheduled to begin 9/1/06, the Title V MCH program

will be mapped in terms of current internal capacity and resources devoted to early childhood, MCH relationship to other outside stakeholders and the challenges and opportunities these present, and the MCH leadership role in carrying out the ECCS implementation plan.

Wisconsin State Laboratory of Hygiene - The Wisconsin State Laboratory of Hygiene (WSLH) is the state's public health and environmental laboratory. The mission of the WSLH is to develop and provide essential public health laboratory support to communities, agencies, and private health providers consistent with the public health goals of the state.

- **Newborn Screening Program** - Wisconsin State Statute 253.13 establishes the WSLH as the contract entity to provide newborn screening laboratory services for DHFS. In addition, WSLH is authorized to impose a fee for tests performed sufficient to pay for services provided, and to pay the DHFS an amount deemed sufficient by DHFS to fund the provision of diagnostic and counseling services, special dietary treatment, and periodic evaluation of screening programs.

- **Family Planning Program** - The WSLH also provides other laboratory and support services to support the MCH and public health programs including the Wisconsin Family Planning Program. The WSLH provides sexually transmitted disease testing services as part of the Wisconsin Infertility Prevention Program. The WSLH also provides cytology services to support cervical cancer screening within the family planning program and the Wisconsin Well Woman's Program.

Within the DPH, Bureau of Health Information and Policy

The legislatively mandated state health plan entitled *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public,* is administered by the Bureau of Health Information and Policy (BHIP) and transcends the entire Department of Health and Family Services. This plan has close ties to the Bureau of Community Health Promotion. Lead accountability for the following key statewide health priorities from the state health plan are carried out by the BCHP and are directed at improving and protecting health for all, eliminating health disparities, and transforming Wisconsin's public health system. These statewide priorities include:

- Adequate and appropriate nutrition
- Alcohol, substance use and addition
- High risk sexual behavior
- Intentional and unintentional injuries and violence
- Mental health and mental disorders
- Overweight, obesity, and lack of physical activity
- Tobacco use and exposure

The BHIP works with the Bureau of Community Health Promotion (BCHP) staff to meet their needs for a variety of data and information products they use to develop and evaluate maternal and child health programs and to track outcomes. BHIP's Vital Records Section provides licensed access to birth and death records and annual statistical reports on births and infant deaths. The Population Health Information Section works with BCHP to define and produce information products that allow BCHP and local health departments to track health status

measures at the local and statewide levels, including annual public health profiles, the online data query system WISH (Wisconsin Interactive Statistics on Health), and the online Infants and Pregnant Women Community Health Profiles. This section also provides linked birth and program data that enable BCHP to address birth outcome disparities in Wisconsin. The Policy Section assists BCHP with policy development in the areas of minority health, preventive oral health, and state health plan implementation. The Injury Prevention Program works with BHIP in order to accomplish the Wisconsin Violent Death Reporting System, for example.

Oral Health - The Bureau of Health Information and Policy (BHIP) collaborated with the MCH/CSHCN Program by providing 'SmileAbilities', a program supporting families and caregivers of Children with Special Health Care Needs with oral health guidance. In addition, BHIP collaborated with local health departments to provide technical assistance with oral health surveys of third grade children in two Wisconsin counties during 2004 through MCH Consolidated Contracts. These surveys assisted local health departments with needs assessment, baseline data collection and program planning.

Division of Children and Family Services Programs

Prevention of Child Abuse and Neglect - Although funded by DCFS, the nurse consultant (funded by Title V) serves as the program lead and expert providing direction and oversight. The targeted home visiting program authorized by 1997 Act 293, Wisconsin's Child Abuse and Neglect Prevention Program, continues to be funded at the 1999 implementation level of $995,700. Ten sites (9 counties and one tribe), continue to receive funds to implement a comprehensive home visiting program for first-time parents on Medicaid and two flexible funds; one flexible fund for families enrolled in the home visiting program and a second for families at risk of child abuse and neglect as determined by county child protective services.

Governor Doyle supports an expansion of the targeted home visiting program to more counties and tribes and adds a program making available one home visit for all first-time parents throughout the state. Referred to as Family Foundations, the combination of information and referral for all first-time parents and having an additional long-term program of support for parents (who desire more) would provide a strong infrastructure of universal family support services for all new families in Wisconsin. Program outcomes that demonstrate improved family functioning, increased parenting skills, and enhanced child health and development would be monitored as Family Foundations programs are instituted. In addition, this effort would help build an infrastructure throughout communities in the state and likely link with strategies recommended by the Call to Action State Planning workgroups to prevent child abuse and neglect in Wisconsin.

Home Visitation Project - Again, although this funded by DCFS, the leadership and technical assistance comes from the Title V MCH/CSHCN Program. We work closely with and support the efforts of the state child welfare program to prevent and intervene early in child maltreatment. The Milwaukee Family Project was initiated in 1996 in collaboration with DHCF, DCFS, and Bureau of Milwaukee Child Welfare with the creation of the Medicaid Child Care Coordination benefit for Milwaukee County when the Department assumed responsibility for child protection in Milwaukee County. In 2000, we initiated a pilot comprehensive home

visiting program in select zip codes of the city of Milwaukee with high incidence of child abuse and neglect. The DPH, lead by the MCH Program, assumed contract management with Community Advocates, CAP-Network, for the home visiting program services of local Milwaukee community-based organizations.

In February 2004, DHFS Secretary Nelson requested that a program review be conducted by the Office of Program Review and Audit to re-evaluate the effectiveness of the Milwaukee home visiting programs. The audit findings suggested that we consider re-bidding the contract to assure coordination of partners and consistent home visiting service delivery as well as focus on improved engagement of clients into the program, settle on one unified home visiting program model, and clearly identify administrative expectations of the lead agency. In January 2005, DPH and DCHP addressed these recommendations by initiating the re-bidding process for the home visiting program in Milwaukee with issuance of a request for proposals for the Milwaukee Comprehensive Home Visiting Program (For Pregnant Women and Families of Infants/Children through Age 4 Years). The goals of this program are to improve pregnancy and birth outcomes; improve family functioning; promote child health, safety and development; and prevent child abuse and neglect. It is expected that the home visiting program will connect first time expectant mothers and expectant mothers with previous poor birth outcomes to medical care and to provide prenatal care coordination services, beginning in the first trimester of the pregnancy. The evidence-based services will be provided by a team consisting of a professional nurse or social worker partnering with a trained community health worker. The home visits can continue until the child's fifth birthday. Additional child and family objectives are:

- Assure that infants of mothers enrolled in the program have access to appropriate preventive health care services and to provide child care coordination services until the child's fifth birthday.
- Provide family-centered, strength-based services delivered in the home with enough intensity and over a sustained period of time sufficient to produce positive behavior changes in the areas of parent leadership and parent-child relationship, and to secure and maintain adequate formal and informal sources of social support.
- Promote parent leadership, as demonstrated by the ability to maintain a stable home and to handle routine child-related, household and family responsibilities.
- Promote positive parent-child relationships, including providing nurturing care, positive guidance and discipline, and a developmentally appropriate and safe environment for the infant and young child.
- Provide adequate social support to the family, including health care, encouraging the use of informal and formal support systems and available community resources.

A strong evaluation component will be initiated at the onset of the program. A training contractor to provide initial and ongoing training on best practices for the home visitors and their supervisors is being established with University of Wisconsin-Milwaukee Extension because of their demonstrated skills and abilities to provide quality training for professional and paraprofessional staff. The selection of the home visiting vendor is pending with anticipated program start-up occurring by late summer 2005.

Brighter Futures - Funded by the DCFS, the Brighter Futures Initiative (BFI) supports evidenced-based youth development and prevention strategies to achieve the following

legislative outcomes as listed in s.46.99: prevention and reduction of youth violence; alcohol and other drug abuse; child abuse and neglect; teen pregnancy: and, ultimately an increase adolescence self-sufficiency. BFI targets these efforts in nine high risk counties and tribes. The local sites consist of a wide cross section of community public and private stakeholders including the lead county human service agency and, in many cases, their public health and public school counterparts. Current results reflect an array of innovative approaches to what has been long standing community problems. The CSHP Director is the Family Health Section contact for this initiative.

Division of Health Care Financing Programs

Wisconsin's Medicaid Program - Medicaid is the single most important government program to provide access to health care for low- and middle-income children and families. Today, about 1 in 7 Wisconsin residents rely on Medicaid for comprehensive health care coverage they would not otherwise be able to afford. Four major groups received medical services through Medicaid: the aged; the blind/disabled; the Healthy Start population; and recipients who qualified under the former Aid to Families with Dependent Children (AFDC) standards. Of the total Medicaid-eligible recipients, well over half were eligible through AFDC or Healthy Start, accounting for 19% of Medicaid expenditures. The aged/blind/disabled make up approximately 35% of the eligible population and account for 81% of the program expenditures.

The Wisconsin Medicaid budget continued to increase in 2004, in concert with national budget trends for Medicaid. Total expenditures for the program, rose by 9% in the 2003-04 state fiscal year, compared with the previous state fiscal year. Total expenditures were at $4.4 billion in all funding sources. These budget figures include Medicaid, BadgerCare, FamilyCare, and SeniorCare drug benefits. The Legislature in 2005 is deliberating on how to address a $590 million Medicaid budget shortfall, however. An Assembly Committee on Medicaid Reform has convened to deal with the issue. Governor Doyle is committed to preserving health care access to vulnerable populations and has avoided making cuts in Medicaid eligibility.

The Title V MCH/CSHCN Program has had a longstanding working relationship with Wisconsin's Medicaid Program (located in the Division of Health Care Financing) and services that benefit mothers, children, and families in Wisconsin have been jointly developed and managed over the years. These have included: Prenatal Care Coordination; Child Care Coordination; HealthCheck (EPSDT): Targeted Case Management; Services for children with special health care needs including medical home; and oral health. More recently, as the Title V program has taken the lead within the department for addressing racial and ethnic disparities in birth outcomes, we have partnered with the Medicaid Program to find solutions.

The Administrators of the Division of Public Health and Health Care Financing meet on a regular basis to discuss issues of mutual concern. Healthy Birth Outcomes has become a frequent topic, including tackling the issues of eligibility and outreach for pregnant women and infants; prenatal care coordination and child care coordination services; managed care services for pregnant women and infants; and home visitation. Health Care Financing is committed to putting together a Medicaid team to work with us on improving birth outcomes. We will also work with the Medicaid Program as we implement a 5-year home visiting project in the inner

city of Milwaukee to reduce infant mortality and child abuse and neglect. This will provide the opportunity to identify eligibility issues that need attention and to make improvements in the delivery of quality care services to this high-risk population of mothers and infants.

Division of Disability and Elder Services Programs

The DDES coordinates an Adolescent Mental Health Transition Committee, the Wisconsin State Brain Team, an Internal Mental Health /AODA Coordination Committee, a Methamphetamine Response Team, and Wisconsin United for Mental Health group. Title V MCH/CSHCN program staff participate on these groups as needed.

Early Hearing Detection and Intervention - The Part C early intervention program called Birth-3 is located in the DDES in the proposed Children's Services Section. This Section also administers the Children's Long-Term Care redesign and waiver programs and Family Support. The Title V CSHCN Program works closely with this Section. The CSHCN Medical Director serves on the State's Birth-3 Interagency Coordinating Council and on the newly formed Children's Long-Term Care Committee. WSB has integrated EHDI programming with Birth-3 services and MCHB grant funds received by CSHCN have been provided to the Birth-3 Program to improve services for children who are deaf and hard of hearing. The CSHCN Program/Birth-3 have jointly developed and implemented the use of nutrition screening tools to promote early identification of nutrition service needs. Joint surveys and communication have been developed to inform health care providers about Part C and Title V services. The CSHCN Program and the Birth-3 Program (Part C) pooled resources to fund First Step, a 24/7 toll free hotline (includes TTY and language line) and website for parents and providers of children and youth with special health care needs.

In addition, Birth-3 and Child Welfare/Foster Care developed a partnership and protocol for screening for social emotional health. Birth-3 developed a workgroup to address the role of Birth-3 and the service needs of families whose children were diagnosed with autism, as many of the families are eligible for Medicaid services through the Children's Mental Health Waiver.

Supplemental Security Income - Each month, the Disability Determination Bureau (the contracted disability determination agency in Wisconsin) sends the Wisconsin CSHCN Program the names of children under 16 applying for SSI or who are having their eligibility re-determined. These families are sent information about the Regional CSHCN Centers along with other resources. In addition, the Regional CSHCN Centers maintain contact with Social Security Administration offices in their region. The Social Security Administration office is a represented on the statewide Healthy and Ready To Work Consortium along with other transition stakeholders.

Suicide, Bullying and Violence Prevention - In collaboration with the Bureau of Mental Health and Substance Abuse and the Injury Prevention Program topics of suicide, bullying, and violence prevention are frequently discussed. Within the Bureau of Aging and Long term Care Resources, the discussion focuses on fall prevention for the aging population.

Department of Public Instruction Programs

Comprehensive School Health Program - The Department of Health and Family Services and the Department of Public Instruction have had a long standing partnership since 1993 under a joint agreement to implement the Comprehensive School Health Program. This agreement is based on a CDC model that encourages both the state education and health agencies to broadly collaborate on the improving health status and education outcomes for school age youth. DHFS and DPI recently signed a new Memorandum of Agreement (MOA) covering the period of March 1, 2004 to February 28, 2008. DPI is the recipient of the Center for Disease Control's/ Division of Adolescent School Health Grant and subcontracts with DHFS to help them carry out the intent of federal agency. In addition to the MOA, DHFS and DPI works collaboratively to reduce childhood and youth obesity, tobacco addiction, improve nutrition, address new health challenges around early warning signs of youth cardiovascular risk, and widely distributed Wisconsin Youth Risk Behavior Survey.

Abstinence, HIV, STD, Teen Pregnancy Prevention Supplemental Grant - The Department of Public Instruction furthered their partnership with the Department of Health and Family Services by encouraging our state agency to be lead applicant for the above mention grant for the FFYs 2004-2005 and 2005-2006 to further improve the coordination, communication and collaboration of state and local providers with expertise in youth risky sexual behavior. Specific outcomes will include a detailed summary of two networking and capacity building events, ten statewide youth listening sessions, and a central youth risk behavior data website with links to a broad range of state and national partners.

Universal Newborn Hearing Screening - The Wisconsin Sound Beginnings (WSB) Program has developed a strong and unique partnership with the Wisconsin Educational Program for the Deaf and Hard of Hearing – Outreach (WESPDHH-Outreach) Program within the Department of Public Instruction. The WSB Program developed a notebook for families with children who are deaf or hard of hearing and WESP-Outreach has assumed the cost and responsibility for maintaining and reprinting this valuable resource. Other WSB grant funded initiatives have been institutionalized through the collaboration with WESPDHH – Outreach such as the Annual Parent Conference and consultation to local Birth-3 programs serving children who are deaf or hard of hearing. A unique program called Guide-By-Your-Side was developed as a joint WSB/WESPDHH initiative and is funded through DPI preschool discretionary grant dollars. The GBYS Program is overseen by the Birth-6 Interagency D/HH workgroup, which includes DPI administrators, CSHCN medical director, as well as program staff. GBYS is now being organized and funded through the WESPDHH with active support and participation from the WSB Program. With new funding provided by MCHB the GBYS program will be further expanded.

Special Education Programs, Autism - In 2002 the Department of Public Instruction received a State Improvement Grant for Students with Disabilities to improve outcomes for students with disabilities birth to 21. MCH/CSHCN staff participate on the statewide steering committee and on several of the grant's statewide initiatives. These projects include: Pre-service Training Program, Centralized Professional Development System, Parent Leadership, Parent Education, Promotion of Early Childhood Program Support, Birth-3 Transition, Implementing Integrated

Preschool Settings, Expansion of Preschool Options Project, and Expansion of WI Assistive Technology Initiative. In addition, DPI provides preschool discretionary grants which interface with Wisconsin Sound Beginnings and the Wisconsin Early Child Care Comprehensive System grant

The Waisman Center, as our state designee, applied and received a CDC Autism and Other Developmental Disabilities Monitoring Network grant. Before staff are able to move forward in data collection, they are waiting agreement from the Federal Department of Education and the Center's for Disease Control regarding confidentiality issues in sharing children' s school records. This grant should help gain an understanding of what appears to be an increase in the prevalence of autism spectrum disorders.

Injury - The Injury Prevention Program works closely with the Department of Public Instruction on suicide prevention and bullying prevention. In addition, DPI staff serve on the Injury Coordinating Committee for the purpose of giving program advice and direction.

Because injury prevention is a crosscutting issue it has resulted in many collaborations and partnerships with other state agencies and programs to include the Departments of: Transportation, Natural Resources, and Justice.

Department of Transportation Programs

Motor Vehicle-related Injury and Deaths - The Department of Transportation serves as a member of the Injury Prevention Program's Injury Coordinating Committee (ICC) and the EMSC Advisory Board. The Injury Prevention Program is actively involved with the promotion of injury prevention initiatives supported by the WI DOT, i.e. Child Passenger Safety, Rural Seat Belt Initiative, Click It or Ticket Campaign. Collaboration continues on an ongoing basis to promote the *Healthiest Wisconsin 2010* injury objective related to reducing motor vehicle related injuries and deaths. Staff from the Injury Prevention Program have been part of DOT conference planning committees, speakers at DOT related conferences, partners in developing and disseminating information statewide, and serve as state injury expert resources for national review panel discussions (Motorcycle Program, Traffic Records Coordinating Committee).

Firearm Safety, ATV, Boating, and Snowmobile Safety - The Injury Prevention Program works with the Department of Natural Resources on related issues and examines their education and policies related to injury prevention and intervention.

Statewide Child Death Review Team - The BCHP Chief Medical Officer is an appointed and active member of the statewide Child Death Review (CDR) Team located in Wisconsin's Department of Justice. The Injury Prevention Program also is present at the meetings providing data, updates on the CASEPOINT system (real time web based reporting system for Medical Examiners and Coroners) and the Wisconsin Violent Death Reporting System. Representatives from the national MCH Center for Child Death Review have been providing technical assistance to Wisconsin's Title V staff as we develop the statewide Child Health and Prevention of Injuries and Deaths project and work to strengthen the statewide CDR team.

Lt. Governor's Office Programs

Women's Health - The Office of the Lt. Governor organized an economic development initiative, *Wisconsin Women = Prosperity* on June 26, 2003. The vision of this initiative is "to ensure that women participate fully in Wisconsin society, so that they may make their best contributions in every level of the workplace as well as in corporate, political and civic realms; and to drive economic growth for our state by increasing the success of women". This is a public/private partnership to engage women, civic leaders, and business to focus on the role of women. Within this context, the health status of women, health disparities, and access to affordable health care are core issues that are addressed. Family planning and related reproductive health access are core issues to be addressed.

Governor's Office Programs

KidsFirst - In May 2004, Governor Jim Doyle announced his *KidsFirst Initiative* that places a priority on investing in children and families. The four focus areas of *KidsFirst* are: Ready for Success, Safe Kids, Strong Families, and Healthy Kids. This Governor's initiative enhances supportive services for families and their children.

The Governor's budget priorities are threefold: grow Wisconsin's economy, maintain the health care safety net, and promote *KidsFirst* and education initiatives. *KidsFirst* activity is an investment in families and their children that cuts across many state departments including DPI, DHFS, Corrections, and DWD. DHFS *KidsFirst* program priorities include oral health (year-round dental clinics for low-income children and expansion of Seal-a-Smile dental sealant program); healthy kids initiatives (prenatal care for undocumented women and parental access to the Immunization Registry); improvements for foster care (foster care rate increase and Medicaid coverage for youths ageing out of foster care); focus on the State child welfare system (implementing the Program Enhancement Plan and pilot projects for mental health and substance abuse screening, assessment and treatment strategies); improvements of child welfare in Milwaukee (expanding safety services, establish a mental health stabilization clinic, and establish an Ombudsman office); and promote strong families (implement Family Foundations universal and targeted home visiting programs and a female offender reintegration program).

In his *KidsFirst Initiative,* Governor Doyle recognized the need to improve access to dental care in Wisconsin. The initiative includes:

- Increasing access to dental sealants, one of the most effective strategies in fighting tooth decay. The Governor's 2005-07 budget proposal doubles the funding for the Healthy Smiles for Wisconsin (Seal-a-Smile) program to $120,000 annually.
- Allowing Medicaid reimbursement to pay for topical applications of fluoride to reduce the risk of decay. In February 2004, Governor Doyle directed Medicaid to reimburse providers for topical applications of fluoride. These applications can be provided by nurses and dental hygienists employed at certified HealthCheck nursing agencies, physicians, physician assistants, and nurse practitioners.
- Providing funding to technical colleges to provide dental care to low-income and uninsured children and to train students to be dental hygienists and assistants. In his 2005-07 budget proposal, the Governor included $86,100 annually to help two technical

colleges expand their efforts to train dental health professionals and provide services to low-income and uninsured children.
- Certifying dental hygienists as Medicaid providers.

B2 (c) Building and enhancing collaborations with local public and private organizations

The MCH/CSHCN Program interacts within its DPH organizational structure which consists of DPH regional offices and local health departments. The MCH/CSHCN Program fosters close working relationships with the Wisconsin Chapters of AAP, WAFP, and ACOG. The established advisory committees are also critical collaborators.

DPH Regional Offices - The Regional Offices primarily function as information pipelines through which central office and local health departments communicate. The Division of Public Health (DPH) Regional Offices have the responsibility to plan, promote, implement and evaluate comprehensive state and local public health programs and services, and provide professional development opportunities. There are five DPH Regional offices located in: Madison, Milwaukee, Green Bay, Eau Claire and Rhinelander. Regional Office staff provide contract monitoring, technical assistance and training related to family and community health, communicable disease prevention and control, chronic disease prevention and health promotion, environmental health, and injury prevention. They also inspect facilities licensed by DPH, including restaurants, motels, swimming pools, tattoo and body-piercing facilities, and bed and breakfast establishments.

Organizationally, the Regional Offices are placed within the Bureau of Local Health Support and Emergency Medical Services *(see Attachment D - DHFS, DPH Organizational Charts [May 2005])*. The Bureau of Local Health Support and Emergency Medical Services has key relationships with all Bureaus in the Division of Public Health, other Divisions within the Department of Health and Family Services and other state agencies, local health departments, community-based organizations, private voluntary organizations, and academic and health care provider networks.

Local Health Departments - Wisconsin has 72 counties and 96 local health departments. In addition, Wisconsin has 11 Tribal Health Centers and the Great Lakes Inter-Tribal Council *(see Attachment E - Wisconsin Tribal Health Centers)*.

The Wisconsin Legislature has given broad statutory and administrative rule authorities to state and local government to promote and protect the health of the Wisconsin population. Wisconsin Chapter 251, Local Health Officials, defines the establishment of a local health department; local board of health members and their powers and duties; local health departments levels of services and duties; the qualifications and duties of the local health officer; and the jurisdiction of the local health department. Local health departments are expected to address the core public health functions: assessment, policy development, and assurance.

According to Wisconsin HFS 140 Public Health Review, the DHFS is required to formally review all local health departments at least every 5 years to determine if they meet the

requirements of either a Level I, II, or III health department. HFS 140 reviews are presently being conducted.

Title V Statewide Projects - According to Title V's Authorization of Appropriations (Section 505), states must have a "fair method" to allocate Block Grant funds within the state. Approximately 60% of Wisconsin's Title V funds are released as "local aids". A portion of these "local aids" are identified for significant statewide initiatives. Allocating funds for statewide initiatives is done through a fair, competitive Request for Proposal (RFP) process.

Wisconsin's statewide projects exist to: develop systems of services and infrastructure building activities to promote uniform, cost effective, quality services no matter where someone resides in the state; develop partnerships with other maternal and child health providers that can help to influence public policy; make available high-level expertise on low incidence conditions; be in the forefront of addressing emerging health needs in a systematic, non-duplicative way; and make services accessible to families, so families can find the system of care they need when they need it.

Wisconsin's current statewide projects were scheduled to end December 31, 2004 but DHFS Secretary Nelson decided to extend existing contracts for an additional 6 month period (until June 30, 2005). During this period, the MCH/CSHCN Program worked on developing the "next generation" of statewide projects (that would begin July 1, 2005 and end December 31, 2010).

Because of this serious commitment, the process to identify significant, statewide initiatives is comprehensive and thorough. The process to determine the "next generation" of statewide projects began with the 2004 Listening Sessions. As previously mentioned, over 350 participants were asked for their suggestions and input during the Listening Sessions. Their suggestions were gathered and MCH/CSHCN staff experts were asked to draft supporting concept papers, as well as submit their own ideas. Next, MCH/CSHCN staff were asked to discuss the merit of each possible statewide initiative and vote on their top choices. Management reviewed the list, asked for more information and presented the finalized list to the DPH Administrator and DHFS Secretary for approval. The DHFS Secretary suggested that pilot projects be included in several of the statewide initiatives with the intent to develop evidence-based model programs that could be replicated, statewide.

There is $760,000 available, on a competitive basis, for five statewide projects for the first 12 month period. This amount is slightly less than previous years because of the federal reallocation of funds using 2000 Census data. (Wisconsin received almost $700,000 less funds in 2004 as a result of the re-allocation.)

The five recommended statewide projects are:

1) Statewide Program to Improve Infant Health and Reduce Disparities in Infant Mortality (includes a pilot project)
2) Wisconsin Genetics System
3) Statewide System to Improve Child Health and Prevent Childhood Injury and Death (includes a pilot project)

4) Statewide Program to Improve Maternal Health and Maternal Care (includes a pilot project)
5) The Wisconsin Parent to Parent Matching Program

Successful applicants will be notified in early summer and activities will begin in July 2005 *(see Attachment F - Detailed description of each statewide project).*

Regional CSHCN Centers - In Wisconsin, children, youth, and families are served through five Regional Children with Special Health Care Needs (CSHCN) Centers. Each Regional Center has distinct characteristics (located in regional hospital, children's hospital, academic training center, local health department, and family resource center) that collectively present a variety of viewpoints and areas of interest and influence. The creation of the Regional Centers in January 2000 was in response to a series of assessments conducted throughout Wisconsin with families and providers along with technical assistance from national experts over the course of several years. Families and providers indicated a need for easy access to information, referral and follow-up services. Families wanted to be linked to the parent support services such as parent-to-parent networks. Families and providers wanted access to technical assistance and educational opportunities. Families and providers recognized a need for care coordination services that included health benefits counseling. The Regional CSHCN Centers are to: provide information, referral, and follow-up services including health benefits counseling; promote a parent-to-parent support network; increase the capacity of local health departments and other local agencies to provide service coordination; work to establish a network of community providers of local service coordination, and provide technical assistance and education in order to support this network of families and providers.

Early Hearing Detection and Intervention - From the beginning the Title V CSHCN/MCH Programs recognized that the success of Wisconsin Sound Beginnings would depend on a collaborative effort of many agencies and persons in both the private and public sector. The EHDI Implementation Work Group and its subcommittees have provided representation from a broad array of stakeholders– parents, healthcare providers (audiology, otolaryngology, hospitals, genetics, pediatrics, family practice, speech/language) and payers, early intervention (state and local level), public health (state and local level), public education, and training institutions. This Work Group has played an instrumental role in determining program priorities. Through contracts Title V Block Grant and MCHB grant funds have been utilized to support the activities of WSB and this collaboration. For example funds were provided: to create an early intervention technical assistance network, to enhance community service delivery for deaf and hard of hearing children through mini-grants to local Birth-3 programs, to develop a network of WSB "champions" statewide and to support the initial annual parent conference. Through collaboration with WSB, private foundation funds were also made available to support the purchase of screening equipment by rural hospitals and nurse midwives.

Early Childhood Comprehensive System - Wisconsin ECCS will devote the next year to strengthening existing partnerships, reaching out to link with new initiatives, and engaging in a variety of strategic planning activities with the goal of being prepared to apply for implementation funds and begin the early childhood comprehensive systems' implementation phase in September 2006.

First we made the breakthrough in the ECCS partnership-building process of the past year by recognizing that working on separate silo-component agendas was counter-productive and duplicative. Thus began the arduous process of blending existing early childhood initiatives into a common plan with linked objectives. Over the next year, The Partnership to Support Young Children document will be expanded to incorporate all required elements and form the foundation for an implementation plan. Second, we are in process of determining the best platform on which to build a future integrated system by completing an assessment of the current early childhood systems infrastructure. The goal is to reach consensus regarding "best practice" methods for linking state, regional, and local level resources in a future comprehensive system. Third, a survey is being conducted to gather information from local early childhood planning groups, frequently lead by local public health agencies, regarding what they need from regional and state level leadership. Finally, the analysis of the MCH-led environmental scan is being completed. This qualitative needs assessment was a major cooperative undertaking of the last year, in that it involved mobilizing many partners and numerous people new to ECCS and will add the perspectives of parents and local leaders to the partnership building process.

Regarding Healthy Child Care America, ECCS's task related to the integration of the HCCA objectives into a future statewide early childhood comprehensive system is to set the stage and invite the many interested stakeholders. ECCS continues to play a role of offering a collaborative, equitable discussion table for those associated in the past with the statewide HCCA grant and those with the Milwaukee HCCA grant. In this regard, ECCS sponsored an intensive day-long "learning/sharing" retreat in February 2005 attended by 25 leaders in primary and public health care including children with special needs, child care including subsidized care and regulatory, academic, and learning standards experts. The American Academy of Pediatrics-designated state pediatric-liaison participated. The lessons learned from the retreat are that Wisconsin has numerous assets, resources, models, and energy to bring to bear in addressing the issues; however, an equal number of gaps in communications and exchange of information abound among all involved partners.

The MCH Program has responded by establishing an ongoing Health Consultation in Child Care workgroup co-chaired a new MCH Pediatric Nurse Consultant. The workgroup is charged with developing a proposal for a stable, sustainable, statewide health consultation in child care initiative as part of a comprehensive early childhood system. Additionally, ECCS supported a "team" of workgroup members to participate in the April 2005 AAP conference for health consultants and is funding the Milwaukee Health Department, administrator of the current HCCA grant, to conduct a feasibility study of what it would take to expand to statewide their internet-based health consultation network that links child care providers with health providers via on-line consultation.

Wisconsin Chapter of AAP - The Wisconsin Chapter of the American Academy of Pediatrics (WIAAP) and the Wisconsin Title V Program have a strong partnership that extends over the past 15 years. We have collaborated on several statewide projects that are intended to contribute to the 2010 goals. Some of these projects include the five Regional CSHCN Centers, the Birth Defects Prevention and Surveillance Program, the WSB, the National Medical Home Mentorship Network, and National Medical Home Learning Collaborative I, and the Wisconsin Medical Home Learning Collaborative. Dr. Carl Eisenberg, Immediate Past President of the WIAAP

serves on the Umbrella Committee of the Newborn Screening Advisory. Joanne Selkurt, MD, FAAP, a past president of the WIAAP, serves on the State MCH Program Advisory Committee and the Board of the Title V funded Children's Health Alliance of Wisconsin. Their leadership has played a central role in Wisconsin Title V's strong commitment to putting the Five Guiding Principles into practice: family-centered care, community-wide leadership, assets/resiliency, outreach, and cultural competence. Dr. Karen Ailsworth is a member of the EHDI Implementation Work Group and an active EHDI Chapter Champion. Dr. Katcher, the Chief Medical Officer for BCHP, and Dr. Fleischfresser, CSHCN Medical Director, both serve on the Executive Committee and serve as chairs of the MCH and CSHCN Committees respectively. Also, Dr. Katcher serves as CATCH Coordinator for the Chapter and Dr. Fleischfresser is a member of the newly formed Pediatric Council. Both have been recipients of the Chapter's Pediatrician of Year award for their work in public health. WIAAP has been actively involved in promoting areas of common interest such as EHDI, injury prevention, access to health care and Medical Home.

Wisconsin Academy of Family Physicians - The Title V Program also has a relationship with the Wisconsin Academy of Family Physicians (WAFP). William Schwab, MD FAFP has served for many years in an advisory capacity to the CSHCN Program and member of the MCH Advisory Committee and as a consultant to the MCHB funded Healthy Ready to Work grant and co-principal investigator to the MCHB funded Autism and Medical Home Project. Dr. Schwab, who coordinates the family practice training program at the University of Wisconsin-Madison and is a parent of a special needs child, played a critical role in planning the restructuring of the Title V CSHCN Program and the creation of five Regional CSHCN Centers. Dr. Milford, the WAFP EHDI Champion, serves on the EHDI Implementation Work Group. Dr. David Smith, MD FAFP was selected as a member of the Wisconsin team that participated in the National Medical Home Mentorship Network. Dr. Smith, Medical Director of the Downs Syndrome Clinic at Children's Hospital of Wisconsin and a parent of a young adult with special needs, has worked with the WAFP Board to support and facilitate the medical home concept. Most recently the CSHCN Program has implemented a Wisconsin Medical Home Learning Collaborative that includes 10 practice teams (pediatric and family practice). Dr. Jean Riquelme, the immediate past-president of the WAFP participates in the Wisconsin Medical Home Learning Collaborative with her practice team. Through collaborations with these organizations and others such as the State Medical Society, the Wisconsin Title V Program has worked closely with primary care providers.

American College of Obstetricians and Gynecologists - In March of 2004, Wisconsin was invited to send a team to participate in a national meeting focusing on tobacco use and cessation for women of reproductive age. As required by the meeting sponsors (Association of Maternal and Child Health Programs, American College of Obstetricians and Gynecologists and Planned Parenthood Federation of America) the Women and Tobacco Team was formed which provided an opportunity for the Title V Program to formalize a relationship with the Wisconsin ACOG Chapter. Using the First Breath Prenatal Smoking Cessation Program as the platform the team developed action steps, which include reaching out to ACOG providers across Wisconsin. One specific focus is to educate these providers about the importance of smoking cessation services for clients and to promote the utilization of the Wisconsin Tobacco Quit line. A system has been established with the Quit line to track ACOG provider sites who enroll in the Quit lines Fax Referral Program, to include interventions clients received and smoking status. This has not

been well utilized to date, therefore we will employ the assistance of the University of Wisconsin Center for Tobacco Research and Intervention's Regional Outreach Specialists to provide training and technical assistance as necessary to providers. Plans are underway to present at a future ACOG conference and to develop a marketing campaign around billing issues for providers, focusing primarily on Medicaid clients.

Key Advisory Groups and Coalitions

MCH Program Advisory Committee - The MCH Program Advisory Committee consists of about 40 diverse members (representing various backgrounds) who come together on a quarterly basis for the purpose of advising the DPH on important maternal and child health issues including children with special health care needs as requested. The meetings provide members with current information, encourage sharing and networking on pertinent information, and the opportunity to discuss issues related to the MCH/CSHCN Program. Its diverse membership includes parents, representatives of local health departments, not-for-profit agencies, tribal agencies, and academic institutions.

The MCH Program Advisory Committee identified Early Childhood Comprehensive Systems as its area of focus for 2004. Members were briefed on state and national ECCS efforts and activities. Committee comments were solicited on the year-one progress report and year-two plan. Advisory committee members formed three subcommittees to further explore ECCS issues: 1) Health in Child Care, 2) Qualitative Needs Assessment, and 3) Milwaukee Focus. Each subcommittee was facilitated by a committee member and MCH program staff person. Subcommittees identified children's needs across the ECCS component areas and identified strategies to address needs. In addition, the Health in Childcare subcommittee reviewed a summary and suggestion paper, the Qualitative Needs Assessment subcommittee reviewed examples of responses from parent focus groups and key informant interview, and the Milwaukee Focus subcommittee reviewed and commented on the Milwaukee area environmental scan. The focus for 2005 - 2006 is currently being discussed.

Public Health Advisory Committee - The Public Health Advisory Committee is a long standing group with a mission to identify issues of public health significance in Wisconsin, to advise the DPH Administrator (State Health Officer) and the DHFS Secretary, and educate and inform key organizations and others on these issues. Five meetings are held each year. The MCH Program Advisory Committee co-chair is a member of this committee.

The Advisory Committee is mentioned in Wisconsin Statutes Section 250.02 (1) revised 1993. "The state health officer may appoint such advisory and examining bodies as are needed to carry out the duties of the state health officer and as provided by law." The Public Health Advisory Committee serves as an umbrella group to foster linkages with the Division of Public Health, its advisory committees, and other public health related organizations, legislative bodies, and administrative and financial services. The charges of the Public Health Advisory Committee are:

1) Advise the DPH Administrator / State Health Officer on major public health policy development and, per request by the DPH Administrator / State Health 0fficer, provide feed back and evaluation of the implementation of current public health policy.

2) Identify emerging issues of public health significance and advise the DPH Administrator/ State Health Officer.
3) Monitor progress toward the state Healthier People in Wisconsin: A Public Health Agenda for the Year 2000 objectives and successor documents, including the 2010 Public Health Improvement Plan.
4) Identify long-range public health issues for consideration by the Secretary of the Department of Health and Family Services (DHFS).
5) Coordinate with other advisory bodies in the DPH to assure communication lines are open and that duplication and fragmentation are avoided.
6) Relate public health concerns to the DHFS Secretary and DPH Administrator / State Health Officer.
7) Provide a mechanism for information sharing by all members of the PHAC and other groups as needed.
8) Educate and inform key decision-making organizations, legislative bodies and others about public health issues and policies.

Emergency Medical Services Advisory Committee - EMSC is comprised of volunteers from the emergency medical services, physicians, nurses, hospital emergency departments, hospital administration, childhood injury and poisoning prevention programs. Meeting monthly, the committee has developed pediatric protocols for emergency response, pediatric safe transport guidelines. Currently it is analyzing data on childhood injury; falls among children is the first topic chosen for analysis, with the goal of developing a tool kit containing local data, evidence-based strategies, to prevent falls. EMSC Committee and program collaborates with the Injury Prevention Program and advisory boards in the areas of child passenger safety, suicide prevention, sexual assault, domestic violence, and bullying.

Maternal and Child Health Coalition - The MCH Coalition is a group of like-minded organizations banding together to promote the health of mothers, children and families and advocate for change, as needed. The MCH Coalition meets at least twice a year alternating between Madison and Milwaukee. The MCH/CSHCN Program has been an ex-officio member for many years.

Wisconsin Oral Health Coalition - Both the Chief Dental Officer and the State Dental Hygiene Officer participate in the Wisconsin Oral Health Coalition. The Coalition is managed by the Children's Health Alliance of Wisconsin. The coalition's membership, consisting of diverse public and private partnerships, works to create meaningful change to improve oral health and access to care in Wisconsin.

March of Dimes - Title V staff participate in the program planning, grants development and review process. The March of Dimes has been a key partner in the Healthy Babies Steering Committee. DHFS Secretary Nelson delivered the keynote at the MOD Prematurity Summit.

B.3 Assessment of Needs of the Maternal and Child Health Populations

This section of the needs assessment uses both quantitative and qualitative data to describe the health status of each MCH population group and cross cutting needs across all population

groups. The data presentation includes a narrative describing the major health issues within the MCH population group and references data detail sheets for the 44 identified needs. Additional data sets are included from the *Healthiest Wisconsin 2010* tracking system.

The Wisconsin Title V Needs Assessments is closely coordinated with *Healthiest Wisconsin 2010,* our statutorily mandated state health plan. DHFS provides statewide leadership to implement the plan; however, all of Wisconsin's public health system partners (government and the public, private, nonprofit and voluntary) share responsibility for implementation. The two overarching goals of *Healthiest Wisconsin 2010* are to protect and promote the health for all, and eliminate health disparities. The majority of the health priorities in *Healthiest Wisconsin 2010* address the well-being and health status of mothers and children. For example, seven of the ten priorities affect birth outcomes. These include: access to primary and preventive health services, adequate and appropriate nutrition, substance use, high-risk sexual behavior, overweight and obesity, social and economics factors, and tobacco use and exposure. DHFS has established accountability to integrate *Healthiest Wisconsin 2010* as a basic business practice into the Department's operations. This includes but is not limited to: identifying evidence-based practices; conducting evaluations, developing policy, linking bureau programs to the priorities and services of the community partners; creating networks to share successes and solve problems, developing and tracking data, developing state-level and local partnerships, providing training, technical assistance, consultation, and leadership. The annual status report for Healthiest Wisconsin 2010 describes initiatives underway. In addition, there is a Web-based data system titled *Tracking the State Health Plan, 2010* which provides statewide data for indicators that measure progress toward meeting *Healthiest Wisconsin 2010* objectives.

The Title V Needs Assessment also corresponds with *KidsFirst: The Governor's Plan to Invest in Wisconsin's Future*. *KidsFirst* outlines priorities to make sure children are ready for success, are safe at home, in school and in their communities; and have the opportunity to be raised by strong families and grow up healthy. The Title V MCH/CSHCN identified needs are matched with several initiatives related to safe kids, strong families, and healthy kids.

In addition, *The Health of Racial and Ethnic Populations in Wisconsin: 1996-2000,* published by the Minority Health Program, DPH, in 2004, complements the state health plan by presenting comprehensive baseline data on African Americans, American Indians, Asians, and Hispanics. The major goals of the report are to monitor progress in eliminating racial/ethnic disparities in the health priority areas, and assist programs and initiatives related to improving the health of racial/ethnic minorities in Wisconsin.

MCH Population - Pregnant Women, Mothers, and Infants and Corresponding Wisconsin's Priority Needs:

- Disparities in birth outcomes
- Contraceptive services (access to)
- Mental health
- Health insurance and access to health care
- Smoking and tobacco use
- Overweight and at risk for overweight

The *Healthiest Wisconsin 2010* health priorities related to social and economic factors that influence health and equal access to primary and preventive health services has the greatest influence on pregnant women, mothers, and infants. Poverty is a major risk factor for death and disability during the first year of life. Racial and ethnic disparities in maternal and child health are public health priorities. Women of all races who live in poverty have higher rates of infant mortality, low birth weight babies, pre-term babies, and delayed entry into prenatal care. Some of the factors related to poverty include lack of education, physical and psychological stress, exposure to high-risk environments (including substance abuse and domestic violence), lack of insurance, and access to care.

The major Wisconsin disparities for birth outcomes, including entry into first trimester prenatal care, low birth weight and prematurity, infant mortality, and sudden infant death, are described below. Corresponding data detail sheets are located at the end of Section B3.

- **Infant mortality (see also B.4.) -** In Wisconsin in 2003, the black infant mortality rate was 15.3 deaths per 1,000 live births, nearly 3 times the rate of 5.3 for white infants. The white infant mortality rate is declining steadily with a near 50% reduction over the past 20 years. In contrast, the black infant mortality rate has varied slightly but has not declined during this period. Comparing Wisconsin's black infant mortality rates relative to other states, for the period 1979-1981, Wisconsin ranked 3rd best. However great strides in infant mortality reduction made by other states, compared to a lack of improvement in Wisconsin has led to sharp drops in Wisconsin's rank relative to other states. For the period 1999-2001, Wisconsin's rank dropped to 32 among 34 states with a sufficient number of black births. The infant mortality disparity of blacks as compared to whites ranked Milwaukee as the 4th worse among 16 U.S. cities (Big Cities Health Inventory, 2003) Analysis of 3-year average infant mortality rates for Wisconsin's Native American population identifies a disturbing trend with rates increasing from 8.4 in 1998 -2000 to 12.9 from 2002-2003.
- **Low birth weight/ preterm -** In 2003, in Wisconsin, 6.6% of all births were infants with low birth weight, black infants (13.2%) were about 2 times as likely as white infants (5.8%) to be born low birth weight. Also in 2003, 11.0% of infants were born prematurely, with a gestation of less than 37 weeks; non-Hispanic black women had the highest percentage of premature babies at 16.7%, followed by American Indian and Laotian/Hmong women at 11%, and white Hispanic women at 10%. Risk factors for premature babies include: unmarried and teen moms, smoking during pregnancy, and less than a high school education.
- **First trimester prenatal care -** Overall, in 2003, 84.7% of pregnant women received first trimester prenatal care. Among black and American Indian women, 73.5% and 71.0% respectively, received prenatal care during the first trimester (compared to 88.3% for White women) followed by Hispanic women with 71.0%, and Laotian/Hmong with 54.2%.
- **Sudden Infant Death Syndrome (SIDS)** - SIDS is the leading cause of deaths for infants from 1 month to 1 year, with most deaths occurring between 2 and 4 months. Since the Back to Sleep Campaign was launched in 1994, the rate of SIDS deaths has decreased dramatically. However, there are still significant differences among racial and ethnic minorities, as the following table shows:

Rate of SIDS per 1,000 live births

Race/Ethnicity	1998-2000	2001-2003
Non-Hispanic White	0.58	0.49
Non-Hispanic Black	2.53	2.76
American Indian	X	3.13
Hispanic	0.74	0.50
Laotian/Hmong	X	X
Total	0.79	0.73

X = less than 5 events; these data are not released to comply with Wisconisn vital records data privacy guidelines.

Other needs related to equal access to primary and preventive health services include newborn hearing screening, breastfeeding initiation and duration, and new parent home visitation. *KidsFirst* promotes a universal home visiting program and services related to giving infants a healthy start and connecting families with support services.

- **Newborn hearing screening -** Hearing loss is the most common congenital birth defect affecting Wisconsin infants. Every year, an estimated 200 babies are born in Wisconsin with hearing impairment, based on an estimated prevalence rate of three newborn per 1,000 with permanent congenital hearing loss greater than 25 dBHL. In 1999, only 28% of newborns were screened for hearing loss prior to discharge. In 2004, 95% of Wisconsin newborns were screened prior to discharge.
- **Breastfeeding initiation and duration** - Data from the Wisconsin Pediatric Nutrition Surveillance System (PedNSS) representing over 50% of the infants born in Wisconsin, including approximately 80% of all minority births, indicate 55% of infants were initially breastfed, 23% breastfed at least 6 months and 15% were breastfed for at least 12 months. Hispanic infants were most likely to be initially breastfed (72%), breastfed at least six months (33%), and breastfed 12 months (22%). American Indian infants are the next group to have higher breastfeeding rates than the other race/ethnic groups for initiation (60%), six months duration (30%), and 12 months duration (20%).
- **New parent home visitation -** In *KidsFirst*, the Governor proposed a universal system of voluntary home visits to offer parent education to every new parent in Wisconsin, with appropriate follow-up and referrals to available services. Currently, 41 of 72 counties (57%) offer a one-time visit for first-time birth parents that is a basic health assessment by a public health nurse. Thirty-one counties (43%) do not offer home visiting.

Two cross-cutting issues for pregnant women, mothers and infants are women's mental health and depression and smoking among pregnant women.

- **Women's mental health and depression -** Women have an approximately 2 times greater rate of major depression than men, and lifetime incidence of a major depressive diagnosis is 20% in women and 12% in men. In Wisconsin, American Indian women had the highest overall rates of hospitalization for depression, 1.7 times greater than the rate for all women hospitalized for depression. In 2003, the suicide rate for females 18 and

over in Wisconsin was 4.3 per 100,000; this rate has not changed much since 1999 when it was 4.6.

- **Smoking among pregnant women -** Smoking during pregnancy is a major risk factor for infant mortality, low birthweight, prematurity, stillbirth, and miscarriage. Overall in 2003, 9,769 or 14% of pregnant women in Wisconsin reported smoking during pregnancy; this rate is higher than the national rate of 11.0%. In terms of racial differences, Native American women continue to report the highest percentage of smoking during pregnancy, nearly 3 times as high as the overall state percentage.

MCH Population - Women of Reproductive Years and Corresponding Wisconsin's Priority Needs:

- Disparities in birth outcomes
- Contraceptive services (access to)
- Mental health
- Health insurance and access to health care
- Smoking and tobacco use
- Overweight and at risk for overweight

The *Healthiest Wisconsin 2010* health priority related to high risk sexual behavior is directed to the population group—women of reproductive years. The primary risks associated with unprotected sexual behaviors are unintended pregnancy, teen births, and sexually transmitted diseases. These health conditions affect the health of the public as well as the social and economic well-being of individuals, families, and communities. Key high risk sexual behavior issues include poverty, discrimination, substance use and transferring knowledge into behavior. Early stages of the Title V needs assessment process identified five needs related to high risk sexual behavior: unintended pregnancy, teen births, HIV/AIDS,and STI's, Chlamydia and gonorrhea, and access and use of contraceptive services.

The data and information included in the detail sheets shows the strong relationship between health disparities. In every racial/ ethnic minority population, teen birth rates exceeded those for whites. Infants of teen age mothers are more likely to have low birth weight or preterm babies and infant death during the first year of life. In addition, teen age girls who give birth have a higher risk of experiencing a subsequent teen birth. Communicable diseases and infections represent serious disease conditions and health disparities in Wisconsin. Sexually transmitted infections disproportionately affect African American, adolescent, and young adult populations. (118-MR)

- **Unintended pregnancy -** Unintended pregnancy has significant social and economic consequences for communities, individuals, and families. Women and families who experience the highest proportion of unintended pregnancy are most vulnerable to insufficient participation in prenatal care and to increased risks during pregnancy, including smoking and drinking. Unintended pregnancy is difficult to measure; however the data detail sheet provides related data on Medicaid as the source of payment for pregnancy and teen births. This is addressed in the data detail sheet for unintended pregnancy.

- **Teen births -** Wisconsin has seen an overall decline in teen births but the state has the highest national ranking in the birth rate for African-American teens. Approximately 85% of the teen births in the state use Medicaid as the source of payment. Children of teen mothers are more likely to be born prematurely and at low birth weight. Teen mothers are more likely to use public assistance, and are less likely to complete high school. This is further addressed in the detail sheet for teen births and in the Governor's *KidsFirst* plan to reduce teen pregnancy.
- **HIV/AIDS -** In Wisconsin, in 2002, 84% of reported HIV infections were reported among males, compared to 16% among females. One percent of HIV of cases were among infants born to mothers with HIV infection. The data detail sheet and the *Healthiest Wisconsin 2010* tracking system provide additional data and information.
- **STIs, chlamydia, and gonorrhea -** Sexually transmitted infections (STIs) including chlamydia and gonorrhea represent the largest group of communicable diseases in Wisconsin. There are significant health, financial, and emotional consequences from STIs: infertility, ectopic pregnancy, reproductive cancer, higher cost of health care, loss of employment and work time, stress on relationships, and grief over fertility loss. The data detail sheet and the *Healthiest Wisconsin 2010* tracking system provide additional data and information.
- **Access and use of contraceptive services** - Access to and use of contraceptive services is critical to reducing unintended pregnancy and teen births. Additional data and information defining the service is available in the detail sheet and in the Governor's *KidsFirst* plan to reduce teen pregnancy.

Two cross-cutting issues identified for women of reproductive years include tobacco use for women of reproductive age and folic acid knowledge and use.

- **Tobacco use and exposure for women of reproductive age -** Data and information on tobacco use is defined in the data detail sheets on youth smoking and smoking during pregnancy. The *Healthiest Wisconsin 2010* tracking system provides additional statewide data and information on smoking and tobacco use and the Governor's *KidsFirst* plan addresses youth smoking.
- **Folic acid knowledge and use -** In 2002, only 20.5% of Wisconsin women who responded to the Wisconsin Behavioral Risk Factor Survey correctly identified birth defect prevention as the reason for folic acid, and only 3.1% reported that they take a vitamin pill or supplement containing folic acid. Additional data and information is defined on the data detail sheet for folic acid and use.

MCH Population - Children and Adolescents and Corresponding Wisconsin's Priority Needs

- Disparities in birth outcomes
- Contraceptive services (access to)
- Mental health
- Medical home
- Dental health
- Health insurance and access to health care
- Smoking and tobacco use

- Intentional childhood injuries
- Unintentional childhood injuries
- Overweight and at risk for overweight

The target population group for children and adolescents relates to the *Healthiest Wisconsin 2010* health priorities that target intentional and unintentional injuries, child abuse and neglect, and access to primary and preventive health services. Injury is the most under-recognized major public health problem facing our country today. An injury is "any unintentional or intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical, or chemical energy or from the absence of such essentials as heat or oxygen." Examples of unintentional injuries are falls, burns, motor vehicle crashes, poisonings, and drowning. Suicides, homicides, and assaults such as sexual assault, intimate partner violence, and child or elder abuse are examples of intentional injuries. In Wisconsin, injury is the leading cause of death for individuals aged 1 to 44 years. In children aged 1 to 14 years, it accounts for more deaths than all other causes combined. Key injury and violence issues that impact children and adolescents include motor vehicle crashes, bicycle and pedestrian injuries, suicide, homicide, and child abuse neglect. The Title V needs assessment identified the following needs: Intentional childhood injuries including suicide, homicide, and child abuse and neglect, and unintentional childhood injuries including motor vehicle deaths and hospitalizations, child passenger safety, and falls.

Access to primary and preventive health services for children and adolescents is a *Healthiest Wisconsin 2010* health priority. In Wisconsin, members of minority groups and children and adolescents in poverty are more likely than whites to lack access to covered services and providers, a consistent source of primary care, and referral services. The Title V needs assessment identified five access needs for children and adolescents: oral health and dental caries, immunizations in young children, blood lead levels in young children, comprehensive school health, and abstinence from adolescent sexual activity.

The major Wisconsin health needs for children and adolescents, including intentional injuries (suicide, homicide, and child abuse), unintentional injuries (motor vehicle deaths, falls, and child passenger safety), oral health and dental caries, immunizations in young children, blood lead levels in young children, comprehensive school health, and abstinence from adolescent sexual activity are described below.

Intentional Injuries (suicide, homicide, and child abuse)

- **Suicide and homicide**
  Injury is a major cause of premature death and disability among children, teenagers, and young adults. Between 1998-2002, 342 Wisconsin children, teenagers, and young adults were murdered and 354 committed suicide. The number of suicide and assault deaths in Wisconsin for the 0-21 age group both increased in 2003, and the primary mechanism used in these deaths was a firearm, particularly in the 15-21 age group. In 2003, the estimated Years of Potential Life Lost (YPLL) in Wisconsin due to suicide in the 0-21 age group was 4,290 years, and for assault it was 3,355 years. The total hospitalization charges for intentional injuries in 2002 for ages 0-21 were $17,795,242.00. For intentional injury hospitalizations, poisoning and cutting or piercing were highest for 15-21 year olds.

- **Child abuse and neglect**
  In 2002, there were 42,698 total reports of child abuse and neglect with substantiations in Wisconsin. The largest number of substantiated reports are for children between the ages of 12 and 14. Between 2000 and 2002, there were slightly more reports and substantiations for female children than males.

Unintentional Injuries (motor vehicle deaths, falls, and child passenger safety)
Injury is a major cause of premature death and disability among children, teenagers, and young adults. Among youths 1-19, unintentional injuries are responsible for more deaths than homicide, suicide, congenital anomalies, cancer, heart disease, respiratory illness, and HIV combined. Unintentional injuries to children are costly. In 2002, the total Wisconsin hospitalization charges for unintentional injuries for individuals 0-21 were $85,950,455.00. Nationally, the number of unintentional injury deaths in the 0-21 age group is on the rise, and this trend is also being seen in Wisconsin. In 2001, the number of unintentional injury deaths for the 0-21 age group was 246, and in 2003, the number increased to 310. The Years of Potential Life Lost (YPLL-65) for unintentional injury deaths for 0-21 was 17,050 years. In Wisconsin, there are almost two times the number of unintentional injuries and deaths than intentional or violent injuries and deaths in this 0-21 age group. More than 2,100 children, teenagers, and young adults up to 21 years of age died from injuries and more than 37,300 were hospitalized from 1998-2002. Of these deaths, 916 died from injuries related to motor vehicles. The leading injury hospitalization for children ages 0-21 were motor vehicle related and fall injuries totaling 4,054 out of more than 37,300 hospitalizations.

Oral health and dental caries - Wisconsin is not alone, as states across the nation are struggling with how to improve access to oral health care. In his KidsFirst Initiative, Governor Jim Doyle presents a strategy for protecting the health and well-being of children and families in Wisconsin. In many areas across Wisconsin, families and individuals have a difficult time obtaining adequate access to dental care services. Finding care is most difficult for those that are uninsured or enrolled in the Medicaid program.

In Wisconsin, 30.8% of children have at least one primary or permanent tooth with an untreated cavity. Compared to White children, a significantly higher proportion of minority children had caries experience and untreated decay. Twenty-five percent of the White children screened had untreated decay compared to 50% of African American children, and 45% of Asian children, and 64% of American Indian children. In addition, children who attend lower income schools have significantly more untreated decay (44.5%) compared to children in both middle (31.7%) and higher income schools (16.6%).

Immunizations in young children - The CDC 2003 National Immunization Survey estimates that immunization series complete among Wisconsin children 24 months of age is 81.2%. The remaining 18.8%, or approximately 20,000 children, are not properly immunized. Children, 24 months of age who are enrolled in Medicaid have a series complete immunization level of only 55%. The Wisconsin Immunization Registry goal is 90%.

Blood lead levels in young children - In 2002, 4.5% of Wisconsin children less than 6 years of age who were tested for lead blood levels, had a blood lead level of 10 ug/dL or more. There are 13 high-risk communities in Wisconsin accounting for 82% of all lead-poisoned children. African American children consistently have the highest levels of lead poisoning, three times the overall total, followed by Hispanic and Asian children.

Comprehensive school health - In the United States, 53 million young people attend nearly 129,000 schools for about 6 hours of classroom time each day. More than 95% of young people aged 5-17 are enrolled in school. School health programs improve the health status of young people, and are critically linked to the health-related behaviors they choose to adopt. Wisconsin currently has no baseline data available. There is a need to develop a survey to identify local education and health policies including: tobacco use prevention, nutrition, violence-prevention, health education, physical education, and physical activity.

Abstinence from adolescent sexual activity - From 1993 to 2003, the percent of Wisconsin high school youth who reported ever having sex decreased from 47% in 1993 to 37% in 2003. The percent of Wisconsin high school seniors who reported ever having sex decreased from 66% in 1993 to 51% in 2003. In a 2003 survey, 92% of teens said teens should receive a strong message from society to delay sex until at least after high school.

There are several cross-cutting issues for the children and adolescent population. They include: alcohol use; tobacco use among youth including secondhand smoke; overweight and at risk for overweight; lack of physical activity; and infant, early childhood, and adolescent mental health.

- **Alcohol use** - From 1993 to 2003, fewer school age adolescents experimented with alcohol before the age of 13 (37% compared to 25% respectively). This improvement is very significant as early onset of alcohol use before the age of 13 is a good predictor for increased use of alcohol and other illicit substances in the succeeding years. A second area of concern is binge drinking (5 or more drinks of alcohol in a row in the past 30 days). Students in 2003 reported alcohol consumption levels comparable to the 1993 levels (28% compared to 29% respectively). The trend over the eleven-year period (1993-2003) has gone as high as 34%. Wisconsin's data is close to the National data where 30% of students reported binge drinking in the past 30 days.
- **Tobacco use among youth** - In Wisconsin, the percent of middle school students who have ever smoked decreased from a high of 16.1% in 2000, to 12.8% in 2002. The percent of Wisconsin high school students who are current smokers declined from a high of 38% in 1999 to 27% in 2002. The current smoking rate in Wisconsin high schools in 2002 is slightly lower than what would have been predicted if the state had continued its trend from the previous years. Despite these reductions in Wisconsin, the almost 80% of 6^{th} graders who have never smoked a cigarette drops to 30% by the 12^{th} grade. Secondhand Smoke – Breathing secondhand smoke can be very harmful to the health of children. Asthma, Sudden Infant Death Syndrome (SIDS), bronchitis and pneumonia, and ear infections are some of the effects of secondhand smoke that are harmful to children. According to the U.S. Environmental Protection Agency, children's exposure to secondhand smoke is responsible for: 1) increases in the number of asthma attacks and severity of symptoms in 200,000 to 1 million children who suffer with asthma; 2) between 150,000 and 300,000 children under 18 months of age suffer from lower respiratory tract infections; and, 3) the number of respiratory tract infections result in 7,500 to 15,000 hospitalizations each year.
- **Overweight and at risk for overweight** - The prevalence of overweight in Wisconsin children from birth to age 5 is 12.2%. Overweight and at-risk-for-overweight has increased among all racial and ethnic groups. The prevalence of at-risk-for-overweight for children aged 2 to 5 or older increased from 13.8% in 1994 to 15.9% in 2003. In

2003, the highest rates for overweight and at-risk-for-overweight were among American Indian (19.2% and 20.0%), Asian (19.3% and 17.8%), and Hispanic (17.8% and 17.6%). Rates for Whites were slightly lower at 11.8% and 15.9%, and Blacks were at 10.1% and 13.6%.

- **Lack of physical activity** - Data from the 2003 Behavior Risk Factor Survey (BRFSS) indicate that only 28% of high school youth participated in moderate physical activity for 30 minutes or greater on at least 5 of the past 7 days.
- **Infant, early childhood, and adolescent mental health** - According to the 2000 National Survey of Early Childhood Health, parents of children 4-35 months of age most frequently have concerns about how their child behaves (48%), how their child talks and makes speech sounds (45%), the child's emotional well-being (42%), and how their child gets along with others (41%). Infant mental health focuses on several complementary issues: (1) promoting a healthy bond between the child and caregivers; (2) assessing and promoting healthy social and emotional development; (3) developing intervention services for children at risk of poor developmental outcomes because of family issues such as domestic violence and substance abuse; and (4) provisions for specialized treatment for children and families who need intensive help because of abuse and neglect or a diagnosed emotional or behavioral disorder.

  One measure of adolescent (ages 15-19) mental health is the suicide rate (per 100,000) for 15-19 adolescents. Other measurers are the reduction of the proportion of adolescents who reported to be sad, unhappy, or depressed, and the prevalence estimates of children and adolescents with a serious mental disorder. According to the Wisconsin 2003 Youth Risk Behavior Survey (YRBS), 20% of students seriously considered suicide in the past twelve months, and 8% reported attempting suicide. Twenty-five percent of high school students felt so sad or hopeless almost everyday for greater than 2 weeks in a row that they stopped doing some of their usual activities. Female students reported that they were more likely than male students to have felt sad or hopeless almost everyday for 2 weeks or greater.

MCH Population - Children with Special Health Care Needs and Corresponding Wisconsin's Priority Needs

- Disparities in birth outcomes
- Contraceptive services (access to)
- Mental health
- Medical home
- Dental health
- Health insurance and access to health care
- Smoking and tobacco use
- Intentional childhood injuries
- Unintentional childhood injuries
- Overweight and at risk for overweight

Children with Special Health Card Needs (CSHCN), are defined as:

> "...those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

This definition is one way of describing CSHCN for specific research and programs. It was developed by the Maternal and Child Health Bureau (MCHB) during 1994 and 1995. The definition is purposefully broad and inclusive, recognizing that children with many different diagnoses and conditions have some important, common needs. This definition was used to develop the CSHCN screener composed of five questions. An affirmative response to any of the five questions leads to one or two clarifying follow-up questions. Any child with an affirmative response to at least one of the five initial questions and affirmative responses to the follow-up question(s) is determined to be a CSHCN.

Five questions were asked about the child; if the child 1) needs or uses more medical care, mental health, or educational services than is usual for most children of the same age; 2) needs or uses medicine prescribed by a doctor other than vitamins; 3) is limited or prevented in any way in his/her ability to do the things most children of the same age can do; 4) needs or gets special therapy such as physical, occupational or speech therapy; and 5) has any kind of emotional, developmental or behavioral problem for which he/she needs treatment or counseling. The follow-up questions ask if the need or condition 1) is because of any medical, behavioral or other health condition and 2) has lasted or is expected to last 12 months or longer.

The CSHCN screener was used as part of the National Survey of CSHCN conducted by Health Resources and Services Administration (HRSA) from October 2000 to April 2002. The resulting data is used by all states for their Title V Maternal and Child Health Block Grant National Performance Measures. The data show that, in Wisconsin:

- 13.4% of all children under 18, or 179,000, have special health care needs, based on the MCHB definition.
- The number of CSHCN varies by race and ethnicity. 13.5% of white children, 14.4% of black children, and 9.7% of Hispanic children have special health care needs.
- More boys than girls are CSHCN; 16.1% compared to 10.7%.
- The number of CSHCN varies by poverty level. 17.3% of children at less than 100% of the federal poverty level (FPL), 15.7% of children at 100-199% FPL, 12.6% of children at 200-399% FPL and 13.5% of children at 400% FPL or more have special health care needs.
- Children's special health care needs have varying degrees of impact on their ability to do things that other children of the same age do. Approximately 24.6% of CSHCN are usually or always affected in their activities by their conditions. 14.1% of CSHCN missed 11 or more days of school in a single school year.
- Nearly 24 percent of parents of children with special health care needs report that they have had to cut back on work or stop working in order to care for their children.

In 2003, the CSHCN screener was added to the Family Health Survey. The results showed a higher prevalence of special needs children in Wisconsin than the earlier SLAITS Survey and is comparable to a 2004 Milwaukee area survey conducted by the Center for Urban Population

Health (CUPH) which used the CSHCN screener. (See Appendix for CUPH report.) Although the Family Health Survey had a smaller number of families surveyed, the survey included more respondents in the Milwaukee metropolitan area, where the largest number of Wisconsin's minority population resides. The Family Health Survey weighted data revealed:

- 22.9% of children under 18, or 306,000, have special health care needs, based on the MCHB definition. (CUPH showed a rate of 18.2% for the greater Milwaukee area and 23.5% for the city of Milwaukee.)
- The number of CSHCN varies by race and ethnicity. 22.6% of white children, 23.3% of African American children, and 22.3% of Hispanic children have special health care needs.
- 26.6% of boys and 18.9% of girls are CSHCN.
- The number of CSHCN varies by poverty level. 30.1% of children at less than 100% of the federal poverty level (FPL), 22.3% of children at 100-199% FPL, 20.3% of children at 200-299% FPL and 21.7% of children at 300% FPL or more have special health care needs.
- Only 83.5% of CSHCN families were satisfied with available health care compared to 86.9% of non-CSHCN families.

Needs identified for the CSHCN population include adequate insurance, medical home, families partner in decision making and are satisfied with services, access to community services, access to dental care, and asthma hospitalizations.

- **Adequate insurance** – In the Wisconsin state health plan, *Healthiest Wisconsin 2010*, insurance coverage is identified as critical to access to health services. Governor Jim Doyle's *KidsFirst* Initiative includes strategies for decreasing the number of uninsured children in Wisconsin. The National Survey of CSHCN revealed that 7% of CSHCN in Wisconsin were uninsured at some point during the year prior to the survey. Of those with insurance, the families of nearly one-third say that their coverage does not meet their needs because of inadequate access to benefits or providers or unreasonable uncovered costs. In Wisconsin, according to the National Survey of CSHCN, and as reported in the Title V National Performance Measures, only 66.6% of CSHCN were determined to have adequate insurance that covers their needs, includes reasonable uncovered costs, and allows the child to see needed providers.

  The Wisconsin Family Health Survey showed that CSHCN were slightly more likely than non-CSHCN to have said they didn't have insurance at the time of the survey (3.7%; 3.3%), were significantly more likely to have Medicaid or other state-supported health insurance (18.1%; 13.4%), and significantly less likely to have insurance through an employer group only (64.9%; 75.3%).

- **Medical home** is a strategy for providers and children and their families to act as partners to identify and access all medical and non-medical services needed for the child/youth to achieve maximum potential. A child with a fully-functioning medical home has a usual source of sick-child care, a usual source of well-child care, a personal doctor, no problem with referrals, receives needed care coordination, has doctors who communicate with each other, and receives family-centered care. In Wisconsin, according to the National Survey of CSHCN, and as reported in the Title V National Performance Measures, only 57% of CSHCN receive care within a medical home.

- **Families partner in decision making and are satisfied with services** - Optimum access to primary and preventive health care presumes a working partnership between the primary health care provider and the child and his/her family when it comes to decision-making, and results in satisfaction with services. In Wisconsin, according to the National Survey of CSHCN, and as reported in the Title V National Performance Measures, 66.6% of parents with a child with a special health care need reported their doctors made them feel like partners and they were very satisfied with services received.
- **Access to community services** - A child with a special health care need by definition requires specialized services. In Wisconsin, there are five Regional CSHCN Centers providing information, referral and follow-up, parent support opportunities, training opportunities for families and providers, and service coordination to CSHCN and their families. In Wisconsin, according to the National Survey of CSHCN, and as reported in the Title V National Performance Measures, 80.7% of CSHCN families reported community-based service systems are organized so they are easy to use.
- **Access to dental care** – Dental care has been identified in more than one national survey as the most prevalent unmet health care need. Both Governor Jim Doyle, in his *KidsFirst* Initiative, and the state health plan, *Healthiest Wisconsin 2010*, identify oral health as a critical need. The National Survey of CSHCN reported that 83.1% of Wisconsin CSHCN required dental services and 92.6% received all needed dental services. 7.4% did not receive all needed dental services, which translates to 13,000 children with unmet oral health needs each year. The Wisconsin Family Health Survey revealed that 4.3% of CSHCN, or 12,800 children, did not received needed dental care. The two primary reasons given were they couldn't afford dental care or had inadequate insurance.
- **Asthma** is a chronic lung condition that can result in hospitalizations and death. From1999 through 2003, 18 children under age 18 died due to asthma. In 2002, the highest asthma hospitalization rate (29.4 per 100,000) was for children ages 1 to 4. The second highest rate (27.1 per 100,000) was for children under 1 year of age. The state health plan, *Healthiest Wisconsin 2010*, specifically targets reduction of asthma deaths under Environmental and Occupational Health Hazards Objective 2: Respiratory Disease. Asthma prevalence is significantly higher among black children (11%) than white and other children (6%). The Minority Health Program of Wisconsin suggests, in *The Health of Racial and Ethnic Populations in Wisconsin: 1996-2000*, that the higher asthma prevalence among African American children is likely due to higher exposure to environmental asthma triggers such as dust mites and cockroaches which occurs in poorer neighborhoods.

There are several cross-cutting issues that affect CSHCN and apply to other populations. They include: access to health care, health insurance, and medical home. All of these needs address consistent, comprehensive, cooperative, accessible and affordable primary and preventive health care services for the entire MCH population in Wisconsin. The needs are completely in agreement with the state health plan, *Healthiest Wisconsin 2010*, which lists Access to Primary and Preventive Health Services as its first goal, and reducing the percentage of the population without health insurance as its first objective.

Cross-Cutting Issues Across All Populations

There are numerous cross cutting issues and needs across all MCH/CSHCN populations. The leading cross-cutting needs are: health insurance coverage, access to health care, and the need for the entire maternal and child population to have to have a medical home, and mental health screening. The 11 *Healthiest Wisconsin 2010* health priorities are directly related to: Access to Primary and Preventive Health Services, Mental Health, and Social and Economic Factors that Influence Health. Access is defined as primary and preventive health care services available and organized in a way that makes sense to individuals and families. This requires people to have financial and non-financial resources and to obtain and use services.

- **Access** - Special access issues exist for particular groups in Wisconsin – those living in rural communities, low-income members of racial, ethnic or cultural minority, and the uninsured and underinsured. Inadequate access to maternal and child health services contributes to an overall poorer health status among the underserved, short and long term adverse health outcomes, and increased rate of preventable disease. In the maternal and child health population, there are direct economic burdens due to inadequate access. This includes the additional cost for a low birth weight infant whose mother received inadequate prenatal care and dental decay in children which affects eating, speaking, and attending school. For the adolescent population, lack of access to abstinence programs or contractive services results in unintended pregnancies, and sexually transmitted diseases. There is a direct association between adverse health outcomes and social and economic factors that influence health.

  "Full access" is defined as comprehensive services with culturally competent high quality medical care. The percent of children less than 12 years of age who receive one physical exam a year is used as one indicator for access to health care for children and is a current Wisconsin's Title V State Performance Measure. This data is collected as part of the annual Wisconsin Family Health Survey. In 2002, 74.4% of children under 12 reported they had a general physical exam in the past year. Poor and near poor families and single-parent families are more likely than better off and two-parent families to have children who are uninsured, have unmet medical needs, and either do not get health care at all or delay health care.

  The minority health report, *The Health of Racial and Ethnic Populations in Wisconsin: 1996-2000*, provides population data by race and ethnicity on income, education, employment, English language, proficiency, foreign-born and refugee populations, residential segregation, and access to telephones and vehicles. According to the 2000 census, in Wisconsin:
  - 32% of African Americans and 22% of American Indians and Hispanics live in poverty compared to approximately 6% of whites.
  - Child poverty rates are higher for all racial and ethnic minority children compared to white children.
  - The Hispanic population has the highest proportion of persons with less than ninth-grade education compared to other racial/ethnic groups.
  - 23.1% of whites have a bachelor's degree or higher compared to 43.0% of Asians, 11.4% of Hispanics, 10.5% of African Americans, and 10.4% of American Indians.

- 8.1% of African Americans, 7.3% of American Indians, 6.3% of Hispanics, 1.8% of Asians and 1.1% of whites have no telephone service available. This impacts telephone-based surveys such as the SLAITS Survey of CSHCN, the Wisconsin Family Health Survey, and the Behavioral Risk Factor Survey.
- Per capita income is $22,548 for whites, $14,962 for Asians, $13,539 for American Indians, $12,186 for African Americans, and $11,499 for Hispanics.

- **Health insurance coverage** - There is a strong relationship between health insurance coverage and access to health care. Wisconsin ranks high in the proportion of people who have health insurance. However, statewide data indicate that the maternal and child health population are less likely to be insured for the entire year. Data detail sheets on access to health care and health insurance coverage provide more detailed information. A detail sheet is also included on the National Performance Measure, CSHCN receive care in a medical home. Although this has been a CSHCN priority for several years, it is now recognized as a priority need for the entire MCH population. This presents opportunities for public health system partners to intervene at the individual, family, and community-wide level and corresponds with the three overarching goals of the state health plan, *Healthiest Wisconsin 2010*.

  Health insurance is specifically delineated in the state health plan, *Healthiest Wisconsin 2010*, as key to whether or not health care services are likely to be sought and obtained. The plan lists Access to Primary and Preventive Health Services as its first goal and reducing the percentage of the population without health insurance as its first objective. The Wisconsin Family Health Survey, in 2003, reported that 7% of children under 18 and 14% of women ages 18-44 had no health insurance coverage for all or part of the year. Hispanics and African Americans were more than twice as likely to be uninsured as whites.

- **Medical home -** A medical home is an approach to providing continuous and comprehensive primary care in a high-quality and cost-effective manner. Medical home includes concepts that make up a complete health care delivery system: usual sources of sick and well care, a personal doctor, no problem with referrals, care coordination, communication among the patient's doctors, and family-centered care. Medical home for CSHCN is one of the Title V National Performance Measures. The National Survey of CSHCN reported that 57% of Wisconsin CSHCN have a medical home. During our needs assessment process, participants determined that the medical home initiative should be expanded to all infants, women and children. A child with a medical home does not use a hospital emergency room as their primary place of care. The Wisconsin Family Health Survey reported in 2003 that less than 1% of white children used a hospital emergency room as their primary place of care. However, 2.5% of Hispanic children and 14.7% of African American children used a hospital emergency room as their primary place of care.

- **Mental health** - Infant and early childhood mental health is of growing interest in public health. Governor Jim Doyle's *KidsFirst Initiative* recommends implementation of the Wisconsin Infant and Early Childhood Mental Health Plan developed by the Wisconsin

Initiative for Infant Mental Health. One of the key recommendations is mental health screening and referral for children birth to age five. The MCH data system, SPHERE, collects information on interventions provided by POCAN and Home Visitation Outcomes Projects, all Title V funded projects (local health departments and private non-profits including CSHCN Regional Centers and Regional Center contractees), and Tribal Agencies (Honoring our Children). (POCAN is the acronym for the comprehensive targeted home visiting program authorized under 46.515 Wisconsin statutes and stands for Prevention of Child Abuse and Neglect.) In 2004, 12,243 Wisconsin children under three were provided 43,327 direct and indirect intervention services including case management, counseling, health teaching, referral and follow-up, and screening.

Adolescent mental health focuses on the child and how he/she manages at home, at school, and in the community. A serious mental disorder must be a condition that persists for at least six months, has a defined diagnosis, and includes functional symptoms and impairments. The Youth Risk Behavior Survey obtains information on suicide ideation and suicide attempts, and feelings of sadness and hopelessness. In 2003, 25% of youth surveyed reported they felt so sad or hopeless almost every day for more than two weeks that they stopped doing some of their usual activities. 20% seriously considered suicide in the past 12 months and 8% attempted suicide.

Women's mental health impacts not only their own lives but the lives of their families since they are most often the primary caregiver, particularly for infants and young children. The state health plan, *Healthiest Wisconsin 2010*, proposes routine mental health screening by 2008 in educational, corrections and primary care settings, and referrals for persons with possible mental health problems to treatment as needed. Postpartum depression affects many women. According to CDC's Pregnancy Risk Assessment Monitoring System (PRAMS), 7% of women report severe depression after delivery and more than half report low to moderate depression. Mortality data from 1999-2002 show 474 Wisconsin women 18 and older committed suicide during those four years, more than 4 per 100,000 women each year.

The 44 Data Detail Sheets are grouped by MCH population and are found in their own file. (see Wisconsin Data Detail Sheets)

B.4 Examine the MCH Program Capacity by Pyramid Levels.

In 2002, Wisconsin's Title V Block Grant award was $11,944,802. For FFY 04 the allocation for each state was calculated using the 2000 Census data for children in poverty. Using this data resulted in 31 states and the District of Columbia losing a total of $5.7 million. Consequently, for FFY 04, Wisconsin's award was reduced to $11,267,938. Followed by yet another smaller reduction, Wisconsin's current award is $11,219,694. The decrease ($11.9 - $11.2) is the biggest percent change (–5.44%) in Wisconsin's Title V MCH Block Grant award history since 1982. It is no surprise that it is increasingly difficult to manage the significant decrease in funding and maintain the needed capacity to provide level services.

The DHFS established a four-year plan that will reduce state operations (primarily staffing) by 19% from $5,077,800 in SFY 2004-05 to $4,048,500 in SFY 2007-08. In addition, all local aids (local health departments, family planning clinics, regional and statewide projects) experienced a 5% cut across-the-board.

B.4 (a) Direct health care and enabling services

B.4 (b) Enabling services

Barriers to health care continue to exist in Wisconsin and access to health care and health insurance coverage have remained as one of Wisconsin's priority needs. Wisconsin continues to cover the majority of those in need through the Medicaid Program. Governor Doyle has attempted to avoid making major cuts in Medicaid eligibility categories. However, other barriers such as availability, acceptability, and duration of health care prevail. For example, currently in Wisconsin Medicaid does not cover prenatal care for immigrant women who would otherwise be eligible based on income and asset guidelines. Seven percent of children, ages 0-17, have no health insurance coverage all or part of the year and 14% of women, ages 18-44 have no health insurance coverage all or part of the year. Also noted is Wisconsin's increasing disparities in birth outcomes as well as among children who have a special health care need. The two data detail sheets: Access to Health Care for Children and Health Insurance Coverage provide additional background to the problem.

Availability of Health Care Services

Availability of Preventive and Primary Care Services - Forty seven of Wisconsin's 72 counties are designated as a dental HPSA. The majority of the designated dental HPSAs are found in the northern and western portion of the state, predominately in Wisconsin's more rural areas. There are 55 Wisconsin's counties designated as a mental health HPSA and 57 as a primary care HPSA. *(See Attachment G for maps depicting the health provider shortage areas (HPSA) – (G1) Mental Health HPSA,(G2) Dental Health HPSA, and (G3) Primary Care HPSA including townships. Also included in Attachment G is (G4) HPSA Ad-Hoc Database Query Selection and (G5) WI J-1 Visa Waver Program)*.

General information regarding the Wisconsin J-1 Visa Wavier Program is found on http://dhfs.wisconsin.gov/localhealth/J-1VISA/index.htm. The Wisconsin J-1 visa wavier program increases access to primary health and mental health care in rural and urban communities that have shortages of primary care physicians and psychiatrists, by helping medical clinics recruit foreign physicians.

Availability of Specialty Care Services - In Wisconsin, there are four large pediatric specialty care clinics and hospitals: UW Hospital and Clinics in Madison, Children's Hospital of Wisconsin in Milwaukee, St. Joseph's Hospital - Marshfield Clinic, and Gundersen Lutheran Medical Center in La Crosse. Access to pediatric specialty services is oftentimes difficult for some rural populations, regardless of Medical eligibility or insurance carrier.

From the Department of Regulations and Licensing as of April 2005, there were 2,915 Occupational Therapists (OT), 1,169 OT Assistants, 3,701 Physical Therapists (PT), 1,136 PT Assistants, and 1,517 Speech/Language Pathologists (SLP) active in Wisconsin. From the Division of Health Care Financing, there are currently 719 SLP, 1,461 OT, and 2,167 PT medical assistance certified therapists in the state. Of these providers, 487 SLP and 1,087 OT/PT providers served children 0-18 years of age.

According to the Wisconsin Birth-3 Interagency Coordinating Council Annual Report (2002-2003 latest available) 2,318 (42.8%) children received OT services, 2,217 (40.9%) children received PT and 3908 (72.1%) children received communication services as part of their early intervention services. This represents 92.3 FTE OT, 79.4 FTE PT, and 160.9 FTE SLP. There were approximately 6 vacant funded FTE therapy positions that could not be filled according to county program administrators.

The National Center to Inform Personnel Preparation and Policy Practice for Early Intervention and Preschool Early Education survey report (Bruder and Stayton) indicates that 47% early intervention (EI) programs perceived a shortage of PT, 51% perceived shortage OT providers, and 75% indicated a shortage of SLP providers. From the NEALS study brief, SLP is the most highly utilized and in shortest supply nationally. This information is consistent with the findings of the Wisconsin Personnel Development Project at the Waisman Center that reports greatest shortage in SLP providers. It is anticipated as the population ages and the demand for these services increase among the elderly that the ability to attract and to retain providers to serve children will become even more challenging.

Availability of Habilitation and Rehabilitation Services - In Wisconsin habilitation and rehabilitation services are generally provided by physical medical physicians and therapists (such as occupational, physical, speech and language). In Wisconsin many specialty care centers have physical medicine and rehabilitation programs that provide habilitation and rehabilitation services. However, physicians' board certified/board eligible in pediatric rehabilitation is limited to a select few centers such as the University of Wisconsin Hospitals and Clinics (2 physicians) in Madison and Children's Hospital of Wisconsin (3 physicians) located in Milwaukee. A pediatric physiatrist (1 physician) located in Appleton serves the Fox River Valley or northeast area of the state. Gillette Hospital (3 physicians) in Minnesota serves in part the western Wisconsin.

Acceptability of Health Care Services

Cultural Acceptability - Data have been presented in the Needs Assessment section and in the State Overview regarding the disproportionate burden of morbidity and mortality among Wisconsin's racial and ethnic minority populations. In addition, two important recent publications: *The Health of Racial and Ethnic Populations in Wisconsin: 1996-2000,* published by the Wisconsin Minority Health Program, DHFS, 2004, and *The Status of Women in Wisconsin,* published by the Institute for Women's Health Policy Research (WPR), 2004, document the disparate health outcomes for women, mothers, infants, and children in Wisconsin's racial and ethnic minority populations.

Numerous and complex factors account for these health disparities. Among these include access to care, defined by Wisconsin's Minority Health Program, as services that "must be convenient, equitable, appropriate, and acceptable to the clients and community being served." As noted in this report and elsewhere, when there are racial, cultural, and linguistic similarities between providers and patients, communication, patient satisfaction, and treatment adherence improves. In Wisconsin, a large percentage of the health providers do not report their race or ethnicity, leaving a gap in our knowledge of the diversity of Wisconsin's healthcare workforce. However, as noted in the WPR report, in April of 2004, the University of Wisconsin Survey Center found that 3 of 5 Wisconsinites believe that discrimination of African Americans continues to be a problem.

Wisconsin's Title V program has a longstanding leadership role in promoting the importance of cultural competency as one of its 5 Guiding Principles, and in promoting the cultural acceptability of services. A partial listing of these Title V services follows: the availability of Spanish and other languages on the MCH Hotline; translation of the Hotline website into Spanish; promotion of the use of the federal guide to Cultural and Linguistically Appropriate Services (CLAS) among all MCH/CSHCN statewide projects; the use of Title V funds to support interpreter services for Spanish and Hmong families; focus groups to improve the delivery of SIDS risk reduction messages to African American and Native American communities; presentation on unlearning racism by the statewide perinatal association to explore perinatal outcomes in the absence of racism; employing bilingual parents to support newly identified children who are deaf or hard of hearing and translating the Guide-By-Your-Side notebook into Spanish; promotion of community health workers in home visitation programs and training to assure culturally appropriate services for families needing substance abuse and mental health services; CSHCN support groups for Latino parents and training in Spanish on understanding health insurance; conducting African American, Hispanic, Hmong, and American Indian parent focus groups for early childhood systems development; participation on committees with the federal Healthy Start projects serving Native American and African American families; and support to the Healthy Babies Initiative regional action teams addressing racial and ethnic disparities in birth outcomes.

Further research is needed in Wisconsin to know the true extent of the cultural acceptability of health care services delivered. Wisconsin's MCH and CSHCN health outcomes indicate that increase efforts are needed in this area. We are committed to working in partnership with Wisconsin's Minority Health Program and the *Healthiest Wisconsin 2010* efforts. We have taken a leadership role in eliminating racial and ethnic disparities in birth outcomes and in promoting culturally acceptable services across the state, and will seek stronger ties with the Center for the Study of Cultural Diversity in Healthcare at the UW-Madison Medical School and with the UW Center for Women's Health Research, a national Center of Excellence in Women's Health, in continuing these efforts.

Linkages exist to promote the provision of services and referrals between primary, secondary, and tertiary care

Congenital Disorders Program - Infrastructure established in Wisconsin ensures that all infants with an abnormal newborn screening (NBS) result receive appropriate follow-up referral, diagnosis, and treatment. Abnormal NBS results are reported from the NBS laboratory at WSLH directly to the infant's identified primary care provider. The primary care provider is then provided with information to enable the coordination of appropriate follow-up testing, with access to expert medical consultants throughout the state. Professional medical consultants voluntarily provide the vital link between NBS Program staff at the WSLH and primary care providers, as well as families. The medical consultants provide expert advice, guidance, and leadership to the primary care provider to ensure that all babies with an abnormal screen receive appropriate, and timely, attention and receive comprehensive care through referral to a center with a multidisciplinary, family-centered, and culturally competent team of healthcare professionals. All medical consultants to the NBS Program are board-certified in their relevant specialty, hospital certified, practicing in conjunction with a comprehensive multidisciplinary center, and available to provide timely back-up.

As stated previously, state statute 253.13 gives the WSLH the authority to impose a fee for NBS tests performed sufficient to fund the provision of follow-up services for families of infants detected by NBS. NBS funds are dispersed from DHFS to fund contracts for services in designated treatment centers throughout the state. In SFY 2004-2005, contracts totaling $1,451,918 were awarded for provision of NBS follow-up services, including dietary counseling and genetic counseling. In addition, $844,339 was available for the purchase of medical foods and formulas necessary for the treatment of certain congenital disorders.

Impact of Emerging Issues

Disparities (including among immigrants, refugees, minorities) - In Wisconsin in 2003, the black infant mortality rate was 15.3 deaths per 1,000 live births, nearly 3 times the rate for white infants (5.3). The white infant mortality rate is declining steadily with a near 50% reduction over the past 20 years. In contrast, the black infant mortality rate has varied slightly but has not declined during this period. Comparing Wisconsin's black infant mortality rates relative to other states, for the period 1979-1981, Wisconsin ranked 3rd best. However great strides in infant mortality reduction made by other states, compared to a lack of improvement in Wisconsin has led to sharp drops in Wisconsin's rank relative to other states. For the period 1999-2001,

Wisconsin's rank dropped to 32 among 34 states with a sufficient number of black births. The infant mortality disparity of blacks as compared to whites ranked Milwaukee as the 4th worse among 16 U.S. cities (Big Cities Health Inventory, 2003)

Analysis of 3-year average infant mortality rates for Wisconsin's Native American population identifies a disturbing trend. Rates are increasing: 8.4 (98-00), 10.7 (99-01), 12.0 (00-02), 12.9 (01-03).

Wisconsin has large Hispanic, immigrants and refugee populations. Hispanics are the fastest growing population in Wisconsin, increasing from 93,194 (1.9% of Wisconsin population) in 1990 to 209,074 (3.8% of the population) in 2002. The actual numbers may be even higher due to the number of immigrants who did not participate in the Census. The Asian population in Wisconsin has also increased significantly from 52,284 in 1990 to 87,995 in 2000. Indeed, Wisconsin is 3rd among U.S. states as home to Hmong refugees from Southeast Asia. Participants in the 2004 Listening Sessions cited the increasing need to have access to quality health care translation services.

Currently in Wisconsin, Medicaid does not cover prenatal care for immigrant women who would otherwise be eligible based on income and asset guidelines. Labor and deliver care is covered, regardless of immigration status under Alien Emergency Medical Assistance in Wisconsin. Governor Doyle has proposed extending prenatal care coverage to undocumented immigrants upon first notice of pregnancy. Increasing access to prenatal care will provide opportunities to improve birth outcomes. In 2002, 69% of Wisconsin's Hispanic women and 53% of Laotian/Hmong women received prenatal care in the first trimester, compared to 88% of the white population in the state. Low birth weight was a factor in 20% of all Hispanic infant deaths. Milwaukee's Hispanic population had the highest infant mortality rate in a recent study of 34 U.S. cities.

Home Visitation for New Parents - Governor Jim Doyle's Summit to Prevent Child Abuse and Neglect: A State Call to Action was convened on April 29, 30, 2004. About 150 Wisconsin leaders who are involved in preventing child abuse and neglect, protecting children, and helping heal victimized children joined the Governor to discuss strategies to prevent child maltreatment. In his opening remarks at the Summit, Governor Doyle said everyone has a role to play in building healthy communities and preventing child abuse and neglect.

Six workgroups were established from the initial work of the Summit to formulate recommendations for long-term strategies to prevent child maltreatment in the following areas: Substance Abuse, Domestic Violence, Children's Mental Health, Family Economic Success, Parent Education and Family Support Systems, and Child Sexual Abuse. The groups' representatives, consisting of state and local programs interested in child wellbeing and consumers of family programs, met from winter 2004 through February 2005. Workgroups submitted preliminary findings and recommendations to the three lead agencies, Children's Trust Fund, Child Abuse Prevention Fund of Children's Health Systems, and Prevent Child Abuse Wisconsin, for assembling into a comprehensive report. This report of the workgroups' recommendations is expected by late summer 2005 and will serve as a blueprint over the next decade for the work of state and local programs to prevent child abuse and neglect in Wisconsin.

This will likely include the impact of the expansion of universal and targeted home visiting programs that are addressed in the Family Foundations initiative.

Child Death Review - Wisconsin's MCH/CSHCN Program mission supports the emerging need to develop a statewide child death review (CDR) system in our state. The development of such a system will provide a framework and collaborative network that will review children's deaths at a local level, both unintentional and intentional or violence-related, and identify and promote the implementation of prevention strategies that will improve the lives of Wisconsin children. *Healthiest Wisconsin 2010* and the Safe Kids, Strong Families, and Healthy Kids components of the Governor's *KidsFirst* Initiative, as well as the National Performance Measures and State Performance Measures address childhood injury and prevention. Also, injury was frequently identified as a priority need in the maternal and child health population subgroups and identified as a Title V MCH/CSHCN needs assessment priority. The need for a child death review system in Wisconsin has been demonstrated as noted above and the plan to promote the formation of partnerships and collaborations with local public health departments, other public and private agencies such as law enforcement, health care professionals, human services, schools, medical examiners/coroners to support child death review teams statewide will be undertaken as a result. Coordinated statewide, these local teams will review the causes of deaths and the data; identify evidence-based prevention priorities and activities, make recommendations for policies, and promote education that needs to be implemented to reduce deaths from injury in Wisconsin.

Early Childhood Comprehensive System - With receipt of the Early Childhood Comprehensive System (ECCS) grant and the increased MCH state-level capacity of a full time coordinator, the early childhood years, from infancy through age five, have become an enhanced focal point within the maternal and child health program. The long term objective of Wisconsin's ECCS project is a major systems building effort and MCH infrastructure realignment that incorporates numerous partners from other early childhood systems. The goal is to work collaboratively to evolve one comprehensive, integrated system of services that supports parents and communities in ensuring the healthy growth and development of children from birth to school entry. We are doing this by clearly placing the needs of the child and his or her parents, family, and significant caretakers at the center of all activities and working around them to integrate and link the significant components that touch and, ideally, sustain and enhance all children's lives: caring, informed parents; secure and stable families; nurturing relationships with other adults; consistent, holistic health care; age-appropriate, enriched educational opportunities; and safe, reliable out of home care while parents work.

Bullying (Violence) Prevention - Recent data collected in the Milwaukee area through an initiative of Fox 6 and MCW (Project Ujima), demonstrates how widespread bullying is in our state. The Injury Prevention Program is working collaboratively with the Adolescent Health Coordinator and other partners, for example, DPI, DOT, WI Prevention Clearinghouse, BMHSAS, Fox 6, academia from UW Madison and MCW to develop a statewide plan for bullying prevention. A workgroup comprised of the above mentioned partners is meeting to develop a plan with the Injury Coordinating Committee providing guidance and recommendations overall.

Suicide Prevention - The Injury Prevention Program facilitates a statewide suicide prevention initiative (SPI) with partners representing both public and private entities such as DPI, Children's Safety Network, BMHSAS, DDES, MCW, UW, MHA of Milwaukee, county mental health professionals, HOPES (an advocacy and survivor group), and public health. A statewide prevention strategy was developed by this group. They hold monthly meetings and are in the process of developing a statewide plan and expanding its initiative to a broader group after attending a Regions 3 and 5 Conference in May 2005. The SPI works to promote awareness and educate people about suicide and suicide prevention. We are promoting the development of community based coalitions and programming to reduce suicides across the age span.

Mental Health - The promotion of mental health with a focus on children and youth, prevention and early identification of mental health disorders, and the assurance for treatment of mental health disorders in children and youth is an emerging issue. The goal is to assure a health system that responds as well to the needs of children and youth's mental health as it does to their physical health and well-being. This system provides a continuum of services to include: mental health promotion; mental illness prevention; early mental health screening, detection, and intervention services; and mental health access to care while reducing the stigma associated with mental illness.

Children's Mental Health is identified in:

- *Healthy People 2010*
- *Healthiest Wisconsin 2010*
- *KidsFirst*: the Governor's Plan to Invest in Wisconsin's Future
- The 2003 President's New Freedom Commission on Mental Health
- The 2000 Surgeon General's Conference on Children's Mental Health
- Guiding Principles for Collaboration between Mental Health and Public Health
- The 1999 Surgeon General's Report on Mental Health

As highlighted in the New Freedom Commission on Mental Health, "as future opportunities emerge to transform health care in America, mental health care must be considered part of the reform necessary to achieve optimal health benefits for the American public." Furthering this concept, mental illness exacts a heavy toll beginning in youth, that missed opportunities for prevention and early identification has created a health crisis leading to unnecessary and costly injury and disability, bullying and failure in school, eating disorders, underage drinking and drug use, risk taking behavior, suicide, intentional injury and violence, family stress and disruption, and juvenile incarceration. The responsibilities for children and youth mental healthcare crosses multiple systems; including daycare, school, recreation, primary care, advocacy organizations, health department, social services, inpatient, residential and outpatient treatment facilities, juvenile justice, child welfare, and substance abuse and other service agencies.

B4 (c) Population-based services for all three populations

Women and Infants

Healthy Babies Initiative - The Title V MCH/CSHCN program collaborates with multiple statewide partners on a Healthy Babies Initiative. The initiative began with a perinatal summit in

2003 to identify new approaches to improve perinatal outcomes and reduce disparities. Summit participants were introduced to a life-span model that identifies disparities in birth outcomes as the consequences of disadvantages and inequities carried over a life course of differential exposures. The life-span approach encourages us to look beyond the 9 months of pregnancy and focus on the following strategies to reduce disparities in birth outcomes: 1) Provide interconception care for high risk women, 2) Increase access to preconception care, 3) Improve the quality of prenatal care, 4) Expand healthcare access over the life span, 5) Provide opportunities for partner involvement, 6) Enhance coordination of family support services, 7) Create reproductive social capital, 8) Address issues that disproportionately affect women of color related to healthcare, education, employment, 9) Undo racism, and 10) Build community partnerships.

The Perinatal Periods of Risk model has also been used by the Healthy Babies Initiative to examine fetal and infant mortality data based on birthweight and age at time of death. The PPOR analysis identified the greatest needs for the state as a whole in the area of Maternal Care (fetal losses, 1500+ grams) and Maternal Health/Prematurity (losses related to very low birth weight). For Blacks and Native Americans, high rates of infant losses between 1 month and 1 year of life were identified. Possible prevention interventions include encouraging appropriate sleep position and environments, breastfeeding, injury prevention, immunizations, smoking cessation and mental health care for parents. Blacks also have high mortality related to Maternal Health/Prematurity. The woman's preconceptional health and health during pregnancy are important to the health of her baby. Appropriate health and social services for women throughout their early and childbearing lifespan may help prevent infant deaths. Native Americans also have high excess mortality related to Maternal Care. Ensuring the availability and utilization of high-risk services and prenatal care may contribute to the prevention of infant mortality.

Following the Healthy Babies Summit, Action Teams formed to support ongoing activities. A Native American Healthy Babies Team meets annually prior to a statewide DHFS-WI Indian Tribes Conference with presentations on best practice strategies to address tobacco use, breastfeeding, and SIDS risk reduction. A meeting in Milwaukee in May 2004 brought together over 150 participants to focus on disparities in African American birth outcomes. Participants identified action steps and existing and potential partners. Select activities from 5 regional Healthy Babies Action Teams include the following: 1) The Western Region Team is distributing a poster they developed, "A Pregnant Women's Wish List," to increase awareness of stress during pregnancy and opportunities for community support; 2) Members of the Southeast Team are focusing on tobacco cessation activities in their organizations and communities; and 3) The Southern region held a facilitated discussion on unlearning racism. In addition, a Healthy Babies Steering Committee is working to increase awareness of disparities in birth outcomes, identify and disseminate evidence-based strategies, and support the Action Teams.

Honoring Our Children Project of Great Lakes Inter-Tribal Council - The Honoring Our Children Project was established as a federal Healthy Start project in 1994 in response to the high infant mortality rate and extremely low health profile of Wisconsin's Native American infants and children. The intention of the project is to strengthen support systems among families and to provide medical, health, and social services in a way that is responsive to the

needs of the women, children, and families. Services are provided at 8 tribal sites and include outreach, health education, case management, interconceptional care, and maternal health screenings including depression screening and referral. A team approach is utilized with an on-site coordinator, outreach worker, and MCH nurse at each participating tribal site. As each tribal community is unique, each team has had to develop individualized approaches.

In 2004, the HOC served 84% (357/423) of the population of pregnant women, 50% (237/476) of the population of interconceptional women, and 88% (538/608) of the infants. Select 2004 outcomes data is provided for all HOC sites; 2003 data for the Wisconsin Native American (NA) population and Wisconsin totals are provided in parentheses: 82% of pregnant women began 1st trimester prenatal care (71% WI NA, 85% WI total); 48% smoked during pregnancy (37% WI NA, 14% WI total); 3.3% of infants had a low birth weight (6.3% WI NA, 6.8% WI total); 9.1% of infants had a high birth weight >9 lb. (19.1% WI NA, 11.1% WI total); 85% of infants under age 2 received the full schedule of immunizations (81% WI total); 45% of infants were breastfed (70% WI total).

Milwaukee Healthy Beginnings Project of the Black Health Coalition - The Milwaukee Healthy Beginnings Project (MHBP) is a federal Healthy Start Project of the Black Health Coalition of Wisconsin. The Black Health Coalition has been working to reduce infant mortality in the city of Milwaukee since 1998. Services are provided for pregnant women and women with children under the age of 2 and include the following: outreach, health education, case management, enhanced clinical services, depression screening, mental health screening, referral and treatment, and AODA screening, referral and treatment. Services were initially targeted to 8 Milwaukee zip codes but expanded to 12 zip code areas in 2001. The MHBP Consortium increases communication between the communities of concern, service providers, government agencies, and other stakeholders. A comparison of clients receiving MHBP interventions with the population of mothers and infants in the MHBP project area was completed for 2003. The data analysis identified 9.2% (21/229) of MHBP participants had a low birth weight baby compared to 13.6% (964/7,097) of women in the project area not receiving MHBP services. Also, 82.5% (189/229) of project participants received first trimester prenatal care compared to 72.5% (5,144/7,097) of others in the project area.

The Milwaukee Healthy Beginnings Project also collaborates with the City of Milwaukee Health Department on the Milwaukee Fetal Infant Mortality Review (FIMR) Program. Through a case review process, an analysis is done for Milwaukee infants who died before their first birthday. A multidisciplinary Case Review Team reviews the life and death circumstances of the infants and identifies factors contributing directly or indirectly to the death. Opportunities are identified to improve the system of services for pregnant women, infants, and families. Recent recommendations include, but are not limited to the following: 1) Increase healthcare provider education on the content and appropriate timing of early and frequent messages regarding the WIC referral process, the Prenatal Care Coordination referral process, and signs and symptoms of preterm labor; 2) Promote improved access to Medicaid contraception services; 3) Ensure that every infant has a well-baby appointment before discharge from a hospital; and 4) Ensure that every mother has been shown a safe sleep environment for her baby before discharge from a hospital.

Family Planning - The MCH program contracts with family planning providers to provide contraceptive and related reproductive health services, and to increase awareness about the importance of these services and how to access services. Standards and guidelines define the content of care and requirements for provision of services. All family planning contractors participate in the Wisconsin Medicaid Family Planning Waiver. Through December 31, 2004, largely due to the efforts of this network of contractors, 55,515 women had been enrolled. In 2004, over 88,000 women received services through the Wisconsin Family Planning Program.

State and federal funds support affordable services to women who are not eligible for Medicaid family planning services. Medicaid eligibility includes women age 15-44 who live in household below 185% of poverty. Laboratory STD services and cytology services are available through the Wisconsin Laboratory of Hygiene resulting in high quality, cost-effective laboratory support services.

Congenital Disorders Program (Newborn Screening Program) - The Wisconsin NBS Program is a collaborative effort between the state DHFS, the WSLH, physicians and other health professionals, and families. State law requires that all infants born in the state are screened for specific congenital disorders either before they are discharged from the hospital of birth or by the first week of life, if born outside of a hospital. Families may refuse the test only if the test conflicts with their religious tenets and practices. The NBS Program currently screens all infants for 26 congenital disorders and has successfully implemented tandem mass spectrometry screening technology.

The DHFS has primary responsibility for directing the NBS Program. The NBS Advisory Group comprised of laboratory experts, parents of affected children, primary medical care providers, specialty medical care providers, nutritionists, genetic counselors, public health professionals, and others involved in the identification and care of infants with congenital disorders. The NBS Advisory Group meets on a biannual basis to review and evaluate the NBS Program. The chair of the Advisory Group is the Chief Medical Officer for MCH. He reports the group's concerns and recommendations to the Secretary of the DHFS.

There are six subcommittees of the NBS Advisory Group. Subcommittees address issues of state and national importance such as establishing appropriate screening cut-offs to maximize sensitivity and specificity, developing protocols to ensure appropriate follow-up care after diagnosis, and evaluating laboratory and clinical protocols to assure an efficient and beneficial program.

Wisconsin Birth Defects Surveillance - In May 2000, Wisconsin Statute 253.12 was enacted to create the Wisconsin Birth Defects Registry. The web-based reporting system collecting demographic, diagnostic and certain identifying information for children from birth to 2 years of age who are born with certain birth defects became operational in the Spring of 2004. Nearly all of the reports have been submitted via the secure website, with the remainder submitted on paper forms. Initial analysis shows that healthcare providers in some parts of the state are reporting reliably while others have yet to begin. A report will be developed in the summer of 2005 that

will provide more information on the number and types of conditions being reported and will highlight areas needing improvement.

Genetics - The intent of the MCH supported Statewide Genetics Services Program is to support direct and indirect services to provide care for individuals and families with or at risk for genetic disorders. While genetic disorders are individually rare, they are cumulatively common and represent a significant public health issue. Through June 30, 2005, the MCH program will contract with the University of Wisconsin-Madison, Clinical Genetics Center to direct the activities of the Statewide Genetics Program. Direct clinical care services are provided in Madison, as well as in outreach sites in Neenah, Green Bay, Ashland, and Rhinelander, and through subcontracts with LaCrosse Regional Genetics Services, Northwest Regional Genetics Network in Eau Claire, and with Milwaukee Children's Hospital for outreach in Racine. In 2004, 1,558 patient visits were held in clinics associated with the Statewide Genetics Program. In addition, educational outreach activities reached 2,893 health care professionals and consumers.

A state plan for genetics services has been completed. The *Genetic Services Plan for Wisconsin*, available at www.slh.wisc.edu, is a problem-oriented, needs-identification guide to address current and future challenges likely to affect the provision of genetic services in Wisconsin. The state is currently in a new procurement process to implement innovative approaches for supporting a system of comprehensive genetic services and activities based on recommendations made in the *Genetic Services Plan for Wisconsin* to begin July 1, 2005. The Wisconsin Genetics System will have five primary program components to include: a genetics advisory committee; a comprehensive genetics needs assessment; formation of a genetics specialty care providers' network; outreach education; and provision of direct services. The selected provider(s) will provide statewide leadership to the Wisconsin Genetics System.

Statewide Genetics also supports the *Wisconsin Teratogen Information Service* and the *Wisconsin Stillbirth Service Program.* The Teratogen Information Service provides a toll free hotline to obtain objective information and counseling for patients and, in some instances, to health care providers regarding pregnancy exposure concerns. In 2004, 282 consultations were provided through the Teratogen service. Due to a decrease in MCH funds available for Statewide Genetic Services, the Teratogen service will likely be discontinued in 2006.

The Wisconsin Stillbirth Service Program is a University of Wisconsin and community collaboration involving approximately 70 birthing hospitals. It is an unreplicated service and unique model of care that provides access to expert consultation to families who have experienced stillbirth. In 2004, 74 consultations were provided through the Stillbirth Service Program. In 2005 the Stillbirth Service Program will initiate a collaborative relationship with the Birth Defects Prevention and Surveillance Program of DPH. State GPR funds for birth defects surveillance will be made available in the amount of $15,000 to support stillbirth service evaluations, data collection, and reporting for the Wisconsin Birth Defects Registry.

MCH Hotline - Public Health Information and Referral (PHIR) Services for Women, Children and Families (hotline services) - Gundersen Lutheran Medical Center – LaCrosse provides services for the PHIR Services for Women, Children and Families contract. The contract

supports services for three different hotlines that address a variety of MCH issues to include: Healthy Start, Prenatal Care Coordination (PNCC), WIC, family planning, and women's health issues. One hotline, Wisconsin First Step, is specifically dedicated to supporting the needs of the Birth to 3 Program and the Regional CSHCN Centers and provides services for families with CSHCN from birth to 21 years of age.

In 2004 the MCH Hotline received 8,549 calls, an increase of 516 calls from 2003. Just over 3% of the calls required Spanish translation. The Wisconsin First Step Hotline received 2,103 calls in 2004, an increase of 604 calls from 2003. In addition to the toll-free hotlines, the website www.mch-hotlines.org has become a well-utilized resource. In 2004 the website received approximately 35,000 hits to the entire site. A searchable database feature was added to the web site in 2003 and is powered by Resource House software. The implementation of this search engine provides users with the ability to query information using a taxonomy (or classification terms) to better accommodate their information and referral needs search. In addition in 2004 a pregnancy assessment tool and a user feedback form were added to the web site and work has begun to translate the web pages into Spanish. (Note: Because of contract difficulties with the web developer data available was sparse and limited for 2004. The contractor has now integrated the web site with their agency's web and will receive support accordingly). The annual formal update to the database occurs in the fall.

B.4 (d) Infrastructure building

Wisconsin's Capacity to Promote Comprehensive Systems of Services

Family Planning - The MCH program contracts with family planning providers to provide services, and to increase awareness about the importance of services and how to access services. This statewide system of services, integrated with other community services, is one way to effect improvements with increased access to quality contraceptive and related reproductive health care. Standards of care and best practices migrate from these publicly-supported services into the larger system of private services.

In addition, the MCH-Family Planning Program has established a contract to provide technical assistance and support, and continuing education to maintain quality, cost-effective services within the statewide system of family planning/reproductive heath services. These services are available to publicly-supported providers and their community partners. These services are also available to all medical providers participating in Wisconsin's Medicaid Family Planning Waiver.

The Wisconsin Medicaid Family Planning Waiver, of which the MCH Program is an integral part, has the potential to provide significant access to many low-income women of reproductive age in Wisconsin. The reproductive health care that normally accompanies contraceptive services can provide a significant amount of routine, preventive care.

Genetics - In preparing the *Genetic Services Plan for Wisconsin*, the status of genetic activity in Wisconsin was compared with the "Guidelines for Clinical Genetic Services for the Public's Health," developed by the Council of Regional Networks of Genetic Services in 1997. The

strengths of the statewide genetics system include the existence of a well-established, well-respected and effective newborn screening program; existence of active outreach programs for care; emphasis on educational efforts that engage both professionals and consumers; and, presence of special expertise regarding the care of individuals with specific groups of genetic disorders. In addition, a genetic counselor serves as the State Genetic Coordinator in DPH, providing the presence of a genetic professional within the state system.

Even with a strong history of recognized excellence in provision of medical genetics services, certain challenges exist. An advisory committee for genetic services is needed to engage stakeholders in systems planning. In addition, available data is insufficient to accurately estimate current service needs or needs for the future. The proposed Wisconsin Genetics System, currently in procurement process, will address these challenges.

Congenital Disorders Program - The NBS Screening Congenital Disorders grant program within DPH funds the system of comprehensive follow-up treatment centers for families of infants identified by the NBS Program. The Congenital Disorders program has established a contract system to promote consistent service delivery between all contracted centers. Contract objectives and performance measures are based on best practices, where available, for the treatment of specified congenital disorders.

The structure of the NBS Advisory Group and its subcommittees also promotes collaboration among key stakeholders in the state to support the comprehensive systems of care needed to appropriately diagnose and treat infants with rare disorders detected by NBS. Members of the NBS Advisory Group represent DHFS, WSLH, local public health, consumers/parents, Wisconsin Chapter of the American Academy of Pediatrics, the State Medical Society, medical ethics, as well as healthcare professionals including physicians, dieticians, genetics counselors, and nurses. The NBS Advisory Group and its subcommittees provides a forum for stakeholders to discuss service delivery and dialogue on emerging issues related to the systems of care available to families. Uniformity in treatment between all follow-up treatment centers is a priority issue.

Universal Newborn Hearing Screening - Maintenance of quality hospital screening programs with established follow-up procedures is a critical issue that WI is attempting to address. From past hospital surveys it is estimated that 50% of hospitals have mechanisms in place to track that infants who failed a re-screen were seen in follow-up by an audiologist, and referred for intervention services. Information gathered from 10 pilot hospitals indicate that the WE-TRAC system (the state web based tracking, referral and follow up system) will be a valuable tool to hospital staff and the WSB Program to assure babies are being screened and are receiving timely follow-up. In addition, the WSB program is working towards the standardization of screening and follow up protocols, regular contact with hospitals, and regular monitoring of referral rates necessary to maintain quality, hearing screening programs.

CSHCN - The Wisconsin CSHCN Program has made significant changes in the past five years to its structure and administration in order to better provide an integrated system approach to care. These program changes were based on a series of assessments (focus groups, regional forums) conducted throughout the state with families and providers along with technical

assistance from national experts. This has improved the CSHCN Program's capacity to impact each of the four constructs of a service system: 1) state level program collaboration, 2) state support for communities, 3) coordination of health components within community systems, and 4) coordination of health services.

Since January 2000, the Wisconsin CSHCN Program has funded five Regional Children and Youth with Special Health Care Needs (CYSHCN) Centers, one in each of the five DPH regions. The Regional Centers are charged to: provide information, referral, and follow-up services; promote a parent-to-parent support network; and increase the capacity of communities (local health departments and other local agencies) to provide service coordination. Block grant dollars are provided to local agencies in every county through contracts with the Regional Center to provide both individual and community system interventions.

The Regional Centers have established a network of "county parent liaisons" (CPL). Many CPLs are directly connected to the local health department or other community agency. More recently, the focus of the Regional Centers has expanded to address elements of the six CSHCN core outcomes. In addition, the CSHCN Program and the Birth-3 Program (Part C) located in the Division of Disability and Elder Services (DDES) pooled resources to fund First Step, a 24/7 toll free hotline (includes TTY and language line). The funded First Step Hotline has evolved to not only provide a 24-hour phone hotline, but a comprehensive website with information on resources for CYSHCN and their families. This hotline is staffed with families of CYSHCN during regular week day hours. The Regional Centers and First Step provide a regional and statewide infrastructure that supports the development of integrated service systems at the local community level for youth and families by local health departments, and other community providers.

These CSHCN Program changes have resulted in greater collaboration with its state partner agencies. For example, the Regional Centers are included in the proposed DDES Children's Long Term Care Redesign as a key resource for referral and follow-up. As DDES implements adult long-term care redesign at the county level, Regional Centers are being asked to assist counties in the transition to the adult long-term care system. The CSHCN Program has partnered with the Division of Health Care Financing (DHCF) on its Medical Home initiatives. Most recently DHCF has included the concepts of Medical Home in its request for proposals for foster care. DHCF has developed a budget initiative that if funded would support coordination services from pediatric to adult care for select youth with complex health care needs. Wisconsin's Healthy Ready to Work Project (HRTW) located at the Southern Regional CSHCN Center (Waisman Center) has resulted in the creation of a statewide Transition Consortium that includes youth and providers from government, academics, pediatric, and adult health care. This group has begun to identify implementation steps necessary to improve transition services at the state and community level. The Regional Centers and ABC for Health, Inc., a non-profit law firm, have partnered to create regional HealthWatch Coalitions that look at access/health care financing issues for CYSHCN and advocate for change. The newly funded CSHCN Integration grant called Wisconsin Integrated System for Communities Initiative (WISC-I) will expand these collaborations with a focus on youth/parent leadership in partnership with Wisconsin Family Voices; medical home and transitions to adult health care in collaboration with Waisman Center; the Children's Hospital of Wisconsin; Medical College of Wisconsin; and the University of

Wisconsin – Pediatric Pulmonary Center, and provide support to continue the work of the Transition Consortium. A network of Regional Center staff with skills in health benefits counseling will be established with training/technical assistance provided by ABC for Health. As a result of the Regional Centers, many local health departments and other agencies are now engaged in community systems interventions to support CYSHCN in their local communities that have not in the past. Each Center in collaboration with HRTW participated in a person-centered transition planning process in local communities within their region and can now provide technical assistance. Small incentive grants will be provided to communities to focus on transition efforts as part of WISC-I. In addition, the CSHCN Program, CHW and Regional Centers have partnered with local primary care practice groups and parents to implement a Wisconsin Medical Home Learning Collaborative beginning in 2004. Medical Home Indexes (collected May and December 2004) demonstrated improvements in all domains for all teams. WISC-I will provide continued support to expand this work. Collectively these efforts have increased coordination of health and other services at the community level.

Early Childhood Comprehensive System - ECCS is offering a different way of doing things: *partnerships* as the key to building a comprehensive early childhood system. However, some of the more seasoned component leaders (one example, is the more established early care and education area) perceived that they had been through the laying groundwork process before and were frustrated that these formative steps were being undertaken. Others, newer to the early childhood world (one example, is the infant mental health initiative area) wanted a full voice in decision-making and did not want it taken for granted that previously developed early childhood agendas included newer component stakeholders' priorities. MCH leadership is a needed catalyst for change – not because there is money in the ECCS grant to "purchase" a unified, integrated service system. MCH provides a level table around which collaborative planning is expected, with equal voice for all component stakeholders. This orientation has stimulated the 25 member ECCS multi-disciplinary Planning Team to break out of the traditional silo-service system out of which each comes. The Planning Team wants to act "outside the box" and has agreed to a common tenet: a commitment to wear the hat of a "comprehensive systems planner" when working to further ECCS's mission.

Although individual agency goals are frequently present, the comprehensive systems planner's perspective, fostered by ECCS, is more focused on cooperation, coordination, and the possible sharing and linking of goals, agendas, resources. Furthermore, the system planner's perspective has led to the Planning Team's referring back again and again to the question: What is *best* for young children? The answer is always before us: babies, toddlers, preschoolers thrive most optimally when their families are offered integrated and culturally acceptable services near where they live.

Efforts to Monitor Community-based Organization Systems

The Wisconsin Title V Program has always contracted with and monitored community-based organizations in the delivery of maternal and child health services, and those for children with special health care needs. While it is true that the Division of Public Health has a special relationship with local health departments, public health services in Wisconsin, including MCH/CSHCN services, have always been provided together with community-based

organizations. During the next five years, community-based organizations will provide statewide MCH and CSHCN services to improve maternal health and maternal care; to improve infant health and reduce disparities; to improve child health and prevent childhood injury and death; to provide a statewide genetics system; to provide a parent-to-parent matching program for families with CSHCN; and to provide regional CSHCN center services. In addition, community-based organizations have always provided a major portion of the family planning/ reproductive health services in Wisconsin.

These services are provided through performance-based contracts and are monitored for their progress in accomplishing contract objectives, through contract deliverables. Title V MCH and CSHCN staff consultants provide on-going technical assistance and monitor these organizations to assure that quality services are provided, services are coordinated with local and state government services, data are appropriately collected through the SPHERE data system, and that the services provided contribute to the overall system of care for MCH and CSHCN populations throughout the state.

B.5 Selection of State Priority Needs

The complete discussion of Wisconsin's needs assessment process, involvement of key stakeholders, and how the state's qualitative and quantitative data analysis pointed to the Wisconsin's 10 priority needs for 2005 is found in Section B.1. In selecting the 10 Priority Needs, we also considered the impact of emerging needs.

Wisconsin's 10 Priority Needs for 2005

1) Disparities in Birth Outcomes: To improve birth outcomes among minority populations.
2) Contraceptive Services (access): To improve access and utilization to contraceptive services.
3) Mental Health: To assure mental health services for all MCH populations
4) Medical Home: To assure a medical home for all children.
5) Dental Health: To assure dental health for all children
6) Health Insurance and Access to Health Care: To assure health insurance and access to health care for all
7) Smoking and Tobacco Use: To decrease tobacco use among women and children
8) Intentional Childhood Injuries: To decrease intentional childhood injuries.
9) Unintentional Childhood Injuries: To decrease unintentional childhood injuries
10) Overweight and At Risk for Overweight: To promote healthy lifestyles including promoting physical activity to achieve healthy weight.

The following table lists Wisconsin's 10 Priority Needs organized by levels of the pyramid and the three maternal and child health population groups.

Wisconsin's 10 Priority Needs	Direct	Enabling	Population	Infrastructure	Women and Infants	Children	CSHCN
Disparities in Birth Outcome				X	X	X	X
Contraceptive Services (access)	X	X			X	X	X
Mental Health	X	X			X	X	X
Medical Home	X			X		X	X
Dental Health	X				X	X	X
Health Insurance and Access to Health Care	X			X	X	X	X
Smoking & Tobacco Use		X			X	X	X
Intentional Childhood Injuries			X		X	X	X
Unintentional Childhood Injuries			X			X	X
Overweight and At Risk for Overweight			X			X	X

C. Needs Assessment Summary

Six of the Wisconsin 2005 needs are basically the same as the needs identified in 2000. The emerging concerns about mental health for all, medical home for all, overweight and at risk for overweight, and further delineating injury into intentional and unintentional moved into the remaining four slots for 2005. This left child care, family and parenting, CSHCN systems of care, and early prenatal care out of the 2005 priority list. However, this is not to say that these needs are no longer considered important, and several could be considered subsets of the new priority needs. As already noted: Issues surrounding health in child care are addressed through the State Performance Measures on mental health (for young children), access to health insurance and access to health care coverage, and unintentional injuries. Family and Parenting issues are addressed through the State Performance Measures on mental health (for young children), medical home for all, and health insurance and access to health care. CSHCN systems of care is included in the State Performance Measures on mental health (for young children), medical home for all, dental health including CSHCN, and health insurance and access to health care. Early prenatal care has been incorporated into our new State Performance Measure on disparities in birth outcomes.

Comparison of Wisconsin's Top Ten Needs 2000 and 2005	
Year 2000 Needs	**Year 2005 Needs**
1. Health disparities	1. Disparities in birth outcomes
2. Teen pregnancy.....	2. Contraceptive services
	3. Mental health for all
	4. Medical home for all
3. Dental access and care	5. Dental health including CSHCN
4. Health access.....	6. Health insurance and access to health care
5. ATODA.....	7. Smoking and tobacco use
	8. Intentional childhood injuries

6. Injury.....	9. Unintentional childhood injuries
	10. Overweight and at risk for overweight
7. Child care	
8. Family and parenting	
9. CSHCN systems of care	
10. Early prenatal care	

Discussion of New State Performance Measures for Contraceptive Services and Dental Health

The follow information is presented for the two State Performance Measures that were changed to reflect new direction for contraceptive services and dental health and the activities to be conducted during the coming year.

State Performance Measure: Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.

1. Contraception and Related Reproductive Health Care--Direct Health Care Services--Women and sexually active adolescents

Expansion of family planning (contraceptive and related reproductive health care) services is anticipated to continue during 2006 - the fourth full year of implementation of the Medicaid Family Planning Waiver. An increased volume of services to women between income levels 185%-250% of poverty is anticipated. This will directly contribute to the objective in Healthiest Wisconsin 2010 to reduce unintended pregnancies among Wisconsin residents to 30%.

In 2006, the Department of Health and Family Services is expected to continue the Family Planning and Reproductive Health Care Council established in 2003. The Family Planning Council's role is to advise the Secretary and foster internal Departmental coordination to insure access to cost-effective family planning services and reproductive health care. The goals include: to provide access to affordable reproductive health care (especially to low-income income women), prevent unintended pregnancy, and deliver cost effective services. Family planning is considered as an integral component of women's health care.

Family planning will continue to be included in DHFS efforts to decrease disparities among women of color with respect to low birth weight -- integrating family planning with other interventions to reduce the incidence of low birth weight.

Several initiatives will be implemented to make contraceptive services more accessible and convenient for women and couples.

2. Promotion and Outreach for Wisconsin's Family Planning Waiver Program--Enabling Services--Women and sexually active adolescents

Activities related to continued promotion and outreach for the Wisconsin Medicaid Family Planning Waiver will continue during 2006.

The Wisconsin Governor's Healthy Kids Initiative, initiated in 2004, identifies a series of steps to improve child health, and will continue in 2006. One of the steps is to "Step up efforts to reduce Teen Pregnancy". Wisconsin has seen an overall decline in teen births in recent years, but there were still approximately 6,500 teens who had babies in 2002. The Medicaid Family Planning Waiver is considered to be one of the most successful programs that addresses this issue.

3. Family Planning Provider Training--Infrastructure Building Services--Women and sexually active adolescents

Technical assistance and support, and continuing education activities for publicly supported family planning providers, as identified above, will continue in 2006. Implementation of provider training in clinic quality improvement issues, resulting from the social marketing research, will continue. Increasing awareness of and access to timely contraceptive services will be a priority.

State Performance Measure: Percent of Medicaid and BadgerCare recipients, ages 3-20, who received any dental service during the reporting year.

1. Fluoride Program--Population-Based Services--Pregnant women, mothers, infants and children including CSHCN

The State of Wisconsin Department of Health and Family Services Division of Public Health were successful at securing Wisconsin Partnership for a Healthy Future funds on behalf of local health departments. These funds will be distributed through a request for application process to local health departments and tribal health centers, targeting the Northern Region. Technical assistance efforts continue to assist with maintaining fluoridation of existing community water systems and increasing the number that consider fluoridation. The School-Based Fluoride Mouth Rinse Program will seek additional methods to initiate school based fluoride mouth rinse programs in elementary schools; on-going promotion and technical is provided.

2. Dental Sealant Program--Population-Based Services--Children, including CSHCN

Healthy Smiles for Wisconsin will continue school-based programs through Wisconsin Seal-A-Smile program.

The oral health component of the Governor's KidsFirst Initiative will be promoted to expand the Wisconsin Seal-a-Smile Program, integrate preventive oral health into health care practice and increase the use of dental hygienists to prevent oral disease.

The GuardCare Sealant Program is on hold due to the deployment of troops.

3. Tobacco Prevention Program--Population-Based Services--Children, including CSHCN

Spit Tobacco Program will contract with the Department of Public Instruction to serve 80,000 fifth grade students in 150 schools throughout the state in the 2002-2003 school year. A "Brewers Day in the Park" will features the program and distributes 10,000 comic books.

4. Maternal and Early Childhood Oral Health Program--Population-Based Services--Pregnant women, mothers, infants

Integrating Preventive Oral Health Measures into Healthcare Practice-training will be offered to federally qualified health centers, tribal health centers, local health departments, medical education programs and Head Start programs serving low income infants and toddlers.

The Regional Oral Health Consultants will serve the five DPH Regions and will be responsible for oral health prevention programs in five DPH Public Health regions and local communities including children with special health care needs.

5. Clinical Services and Technical Assistance--Population-Based Services--Pregnant women, mothers, infants and children, including CSHCN

A SmileAbilities Conference and Circles of Life presentation will be planned.

6. Oral Health Surveillance--Infrastructure Building Services--Children including CSHCN

Four to six county surveys are anticipated to be initiated during the 2006 state survey to establish baseline oral health status for third grade children.

New State Performance Measures for Medical Home; for All Mental Health for All; and Intentional Injuries

State Performance Measure: Percent of children who receive coordinated, ongoing comprehensive care within a medical home.

State Performance Measure: Percent of children, ages 6 months-5 years, who have age-appropriate social and emotional developmental levels.

State Performance Measure: Number of substantiated reports of child maltreatment to Wisconsin children, ages 0-17, during the year.

Activities for the coming year for the new State Performance Measures on Medical Home for All, Mental Health for All, and Intentional Childhood Injuries will be determined during the coming year in conjunction with the Wisconsin Medical Home Initiative and WISC-I Grant; with Wisconsin Infant Mental Health Initiative and the Mental Health and Social-Emotional component of the Early Childhood Comprehensive Systems Grant; and with the Wisconsin Injury Prevention Program, respectively.

The following table outlines Wisconsin's Priority Needs, National Performance Measures and the State Performance Measures for 2006.

Wisconsin's Top 10 Needs	National Performance Measures	State Performance Measures for 2006
1.Disparities in Birth Outcomes • Infant mortality • LBW • Preterm • Early Prenatal care	Percent VLBW Percent VLBW delivered at facilities for high risk First trimester prenatal care	Ratio the of black infant mortality rate to white infant mortality rate
2. Contraceptive Services • Unintended pregnancy • Teen births • Abstinence from adolescent sexual activity	Rate of births among teenagers 15 – 17	Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year
3. Mental Health for all populations groups	Rate of deaths from suicide among 15 – 19	Percent of children, ages 6 months - 5 years, who have age appropriate social and emotional developmental levels
4. Medical Home for all children	CSHCN receive care within a medical home	Percent of children who receive coordinated, ongoing comprehensive care within a medical home
5. Dental Health (including CSHCN, racial/ethnic, linguistic, and geography, income)	Percent of third graders who have protective sealants	Percent of Wisconsin Medicaid and BadgerCare recipients, ages 3 – 20, who received any dental services during the year
6. Health Insurance and Access to Health Care	Percent of children without health insurance	Percent of children less than 12 years of age who receive one physical exam a year
7. Smoking and Tobacco Use • Youth • Pregnant Women		Percent of women who use tobacco during pregnancy
8. Intentional childhood Injuries • Child Abuse and Neglect	Rate of deaths from suicide among 15 – 19	Number of substantiated reports of child maltreatment to Wisconsin children, ages 0 – 17, during the year
9. Unintentional Childhood Injuries	Rate of deaths to children 14 years and younger from motor vehicle crashes	Death rate per 100,000 among youth, ages 15-19, due to motor vehicle crashes
10. Overweight and At Risk for Overweight	Percent of mothers who breastfeed their infants at hospital discharge	Percent of children, 2 – 4 years who are obese or overweight

D. Health Status Indicators

2004 data are required for the Health Status Indicators (HSIs), forms 20 and 21, during the needs assessment year.

Form 20: For the majority of these indicators (with the exception of program data for chlaymdia [#05A and #05B], 2004 data are not available. Therefore, we used the most recent available data (in most cases 2003 data) as estimates for 2004 and so indicated in a data note. Data for #01A - #03C are maintained by the DHFS, DPH, Bureau of Health Information and Policy, Vital Records Section; 2004 data will not be available until 2006. Collection of hospitalization data for the unintentional and non-fatal injury indicators (#04A - 04C) is the responsibility of the

Wisconsin Hospital Association as of September 2003 and access by DHFS to more recent discharge data is pending completion of negotiations on a data use agreement; therefore, we have the four most recent quarters of data available from October 2002-September 2003.

#01A: The percent of live births weighing less than 2500 grams - The percent of live births weighing less than 2500 grams has increased gradually since 2000 from 6.5% to 6.8% in 2003; Wisconsin's percent of low birth infants in 2003 is lower than the U.S. rate of 7.8% in 2002. Twins or other multiple births made up 26.1% of all low birthweight births in 2003**.**

#01B: The percent of live singleton births weighing less than 2500 grams - The percent of live singleton births weighing less than 2500 grams has remained about the same since 2002 when it was 5.2%. In 2003, higher percentages of low birthweight infants were born to: mothers who receive no prenatal care (18.3%), non-Hispanic black women (13.7%), women who smoked during pregnancy (9.8%), teens less than 15 years old (11.8%), women who were unmarried (9.1%), and women with less than a high school education (8.5%).

#02A: The percent of live births weighing less than 1500 grams - The percent of live births weighing less than 1500 grams was 1.3% and has not changed since 2001 when it increased from 1.2%.

#02B: The percent of live singleton births weighing less than 1500 grams - The percent of live singleton births weighing less than 1500 grams has not changed since 2000 when it was 1.0%.

#03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger - The rate of unintentional injuries among children aged 14 years and younger fluctuated during the past 5 years. The rate of deaths in 2003 was 8.1, compared to 8.4 in 2002. From 1999 to 2003, the largest number of deaths was from occupants involved in motor vehicle crashes, followed by death from suffocation.

#03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes - The rate of unintentional deaths from motor vehicle crashes among children aged 14 years and younger has stayed about the same from 2002 to 2003 at 3.6. Since 1999, the rate has decreased when it was 4.5.

#03C: The death rate per 100,000 for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes - Motor vehicle accidents continue to be the leading cause of death for youth 15 through 24 years old. In 2003, the rate of death due to motor vehicle accidents increased to 29.9, up from 27.9 in 2002. Since 1999, when the rate was 24.8, deaths from motor vehicles increased in the 15-24 age group.

#05A and 05B: The rate per 1000 women (aged 15 through 19 years and 20 through 44 years) with a reported case of Chlamydia - Though reported chlamydia morbidity has remained relatively stable among Wisconsin women since 2000, the total annual reported morbidity has increased, with greater numbers of men reported in subsequent years. Increasing focus in the STD Program to reach partners may have contributed to this increase in males

reported with chlamydia. Reported morbidity rates of chlamydia among women over the past 5 years appear to be stable during a time when the volume of screening has steadily increased and significantly more sensitive tests used. This stabilization may be attributable to the impact of the STD Program on reducing morbidity among women through statewide selective screening programs for women at high risk in Wisconsin.

Form 21: These data are demographic and describe Wisconsin's population by number of births and deaths by age group and by race/ethnicity, miscellaneous demographic indicators for Wisconsin's children, and Wisconsin's population by poverty level and urban/rural proportions. 2004 data are required for the needs assessment year. For all these indicators, 2004 data are not available; therefore, we have marked the data "provisional" on the respective form and used 2003 data in lieu of 2004 data. Wisconsin's birth and death data (#07A – 08B) are maintained in retrospective administrative data bases by the DHFS, DPH, BHIP, Vital Records Section; 2004 data will not be available until 2006. Data for #09B come from several state agencies and there is not a consistent methodology across agencies for reporting of race/ethnicity; additionally, program changes and staff turnover are a limitation for reporting these data consistently from year to year; we have used 2004 data if available, and noted if 2004 data were not available. Data for #10 - 12 are estimates from the U.S. Census Current Population Survey.

#06A and #06B: Demographics: Infants and children 0-24 by race and ethnicity - Of the 1,899,068 Wisconsin residents under 25 years of age, 85.6% are white, 8.3% are African American, 5.8% are Hispanic/Latino, 1.2% is American Indian, 2.8% are Asian, and 1.9% are multiracial. The fastest growing ethnic group in Wisconsin is Hispanic/Latino. Although 5.8% of the total population under 25 is Hispanic/Latino, 7.5% of babies less than one year of age are in this group.

#07A and 07B: Demographics: Live births by maternal age and race and ethnicity - In Wisconsin, 69,999 infants were born to women in 2003. Of that total, 9.0% were born to women under 20 years of age, 77.2% were born to women 20 to 34 years of age, and 13.8% were born to women 35 and older. Teen pregnancy continues to be a problem in the African American community. 24.5% of African American babies were born to mothers under 20 while only 7.1% of white babies were born to mothers in this age group. 14.7% of white babies were born to mothers 35 and older while only 6.8% of African American babies were born to mothers in this age group. 5,512 babies were born to Hispanic/Latino women in Wisconsin in 2004. 16.3% of Hispanic/Latino babies were born to mothers under 20 years of age, 76.0% were born to mothers 20 to 34 years of age, and 7.7% were born to mothers 35 and older.

#08A and 08B: Demographics: Deaths of infants and children ages 0-24 by age group and race/ethnicity - 1,292 Wisconsin children died in 2003. 35.1% were under one year of age, 6.6% were 1 to 4, 4.0% were 5 to 9, 5.7% were 10 to 14, 22.0% were 15 to 19, and 26.5% were 20 to 24. Infant mortality is much higher for African Americans than for whites. Of the 214 deaths among African Americans under 25 in 2004, 47.7% (102) were babies under one year of age, a rate of 16.48 per thousand. By comparison, of the 1,019 deaths among whites under 25 in 2004, 31.9% (325) were babies under one year of age, a rate of 5.78 per thousand. 86 Hispanic children died in Wisconsin in 2005. 50% (43) were babies under one year of age, a rate of 8.61 per thousand.

#09A and 09B: Miscellaneous demographic data for children, 0-19 - There are limitations to these indicators: they are not consistently reported by age and race/ethnicity across state agencies, they are not defined consistently (numbers, rates, percentages), and methodologies for their collection and reporting change from year to year and by agency. About 27% of Wisconsin's population is children, ages 0-19. Overall, Wisconsin's children do well: they have a relatively low high school drop out rate, low rate of juvenile crime arrest, and enrollment numbers for Medicaid/BadgerCare have been increasing. However, when examined by race/ethnicity, there are outstanding disparities; for example, there are almost as many black children in foster care home as white children, even though black children comprise 9% of the children 0-19, while white children account for 85%. Other examples are the rates of juvenile violent crime arrest and percentage of high-school drop outs: children of color have higher rates than whites. Other significant disparities for Wisconsin's children are described in Section III. State Overview.

#10: Geographic living area for all resident children 0-19 - In 2003, 1,503,818 children under the age of 20 lived in Wisconsin. 15.4% lived in rural areas and 84.6% lived in urban areas.

#11: Poverty levels - Approximately 5.5 million people lived in Wisconsin in 2004. Four percent (about 220,000) subsisted at less than 50% of the federal poverty level, 9% (about half a million) at 100% FPL, and 24% (about 1.3 million) at 200% FPL.

#12: Poverty levels for children 0-19 - Approximately 1.5 million children under 20 lived in Wisconsin in 2004. Five percent (about 75,000) subsisted at less than 50% of the federal poverty level, 12% (about 180,000) at 100% FPL, and 30% (about 450,000) at 200% FPL.

E. Outcome Measures – Federal and State

The table links the Wisconsin's 10 Priority Needs with the 2006 State Performance Measures and National Outcome Measures.

Wisconsin's 10 Priority Needs	State Performance Measures - (2006)	National Outcome Measures
Disparities in Birth Outcome	Ratio of black infant mortality rate to the white infant mortality rate [Infrastructure]	#2 Disparity between black and white IMR
Contraceptive Services	Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year [Direct, Enabling]	
Mental Health	Percent of children, ages 6 months-5 years, who have age appropriate social and emotional developmental levels [Direct, Enabling]	#6 Child death rate
Medical Home	Percent of children who receive coordinated, ongoing, comprehensive care within a medical home [Direct, Infrastructure]	
Dental Health	Percent of Wisconsin Medicaid and BadgerCare recipients, ages 3 – 20, who received any dental services during the year [Direct]	
Health Insurance and Access to Health Care	Percent of children less than 12 years of age who receive one physical exam a year [Direct, Infrastructure]	#1 Infant mortality rate #3 Neonatal mortality rate #4Postneonatal mortality rate #5 Perinatal mortality rate
Smoking and Tobacco Use	Percent of women who use tobacco during pregnancy [Enabling, Population]	#1 Infant mortality rate
Intentional Childhood Injuries	Number of substantiated reports of child maltreatment to Wisconsin children, ages 0-17, during the year [Population]	#1 Infant mortality rate #3 Neonatal mortality rate #4Postneonatal mortality rate #6 Child death rate
Unintentional Childhood Injuries	Death rate per 100,000 among youth, ages 15-19, due to motor vehicle crashes [Population]	
Overweight and At Risk for Overweight	Percent of children, ages 2-4, who are obese or overweight [Population]	

RELATED OBJECTIVES

November 2004

November 2004

Related Objectives - Federal Healthy People 2010 to the 44 Maternal and Child Health Potential Needs

1. Access to health care for children

Clinical Preventive Care

1-1. Increase the proportion of persons with health insurance.

Target: 100 percent.

Baseline: 86 percent of the population was covered by health insurance in 1997 (age adjusted to the year 2000 standard population). 85% persons with disabilities

Target setting method: Total coverage.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

Primary Care

1-4. Increase the proportion of persons who have a specific source of ongoing care.

Target and Baseline:

Objective	Increase in Persons with Specific Source of Ongoing Care	1997 Baseline*	2010 Target
1-4a.	All ages	86%	96%
1-4b.	Children and youth aged 17 years and under	93%	96%
1-4c.	Adults aged 18 years and older	84%	96%
	Persons with disabilities (all ages)	89%	96%
	Persons with disabilities children and youth aged 17 and younger	94%	96%

*Age adjusted to the year 2000 standard population.

1-5. Increase the proportion of persons with a usual primary care provider.

Target: 85 percent.

Baseline: 77 percent of the population had a usual primary care provider in 1996.

Target setting method: Better than the best.

Data source: Medical Expenditure Panel Survey (MEPS), AHRQ.

2. Health insurance coverage

Same as above

3. CSHCN and families partner in decision making and satisfied with services

None.

4. CSHCN receive care within a Medical Home

Service Systems
16-22. (Developmental) Increase the proportion of children with special health care needs who have access to a medical home.
Potential data source: Title V Reporting System.

5. CSHCN have adequate insurance

Primary Care
1-4. Increase the proportion of persons who have a specific source of ongoing care.
Target and Baseline:

Objective	Increase in Persons With Specific Source of Ongoing Care	1997 Baseline*	2010 Target
1-4a.	All ages	86%	96%
1-4b.	Children and youth aged 17 years and under	93%	96%
1-4c.	Adults aged 18 years and older	84%	96%
	Persons with disabilities (all ages)	89%	96%
	Persons with disabilities children and youth aged 17 and younger	94%	96%

*Age adjusted to the year 2000 standard population.

6. CSHCN and families access to community services

Breastfeeding, Newborn Screening, and Service Systems
16-23. Increase the proportion of Territories and States that have service systems for children with special health care needs.
Target: 100 percent.
Baseline: 15.7 percent of Territories and States met Title V for service systems for Children with Special Health Care Needs in FY 1997.
Target setting method: Total coverage.
Data source: Title V reporting system.

7. Youth with SHCN transition to adulthood

Disability and Secondary Conditions
6-8. Eliminate disparities in employment rates between working-aged adults with and without disabilities.
Target: 82 percent.
Baseline: 52 percent of adults with disabilities aged 21 through 64 years were employed in 1994-95.
Target setting method: 58 percent improvement (parity with adults without disabilities in 1994-95).
Data source: Survey of Income and Program Participation (SIPP), U.S. Department of Commerce, Bureau of the Census.

8. CSHCN access to dental care

None.

9. Unintentional childhood injuries

Unintentional Injury Prevention
15-12. Reduce hospital emergency department visits caused by injuries.
Target: 112 hospital emergency department visits per 1,000 population.
Baseline: 130 hospital emergency department visits per 1,000 population were caused by injury in 1997.
Target setting method: Better than the best.
Data source: National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

15-13. Reduce deaths caused by unintentional injuries.
Target: 20.8 deaths per 100,000 population.
Baseline: 33.3 deaths per 100,000 population were caused by unintentional injuries in 1998 (preliminary data; age adjusted to the year 2000 standard population).
Target setting method: Better than the best.
Data source: National Vital Statistics System (NVSS), CDC, NCHS.

10. Child abuse and neglect

Violence Abuse and Prevention
15-33. Reduce maltreatment and maltreatment fatalities of children.

15-33a. Reduce maltreatment of children.
Target: 11.1 per 1,000 children under age 18 years.
Baseline: 13.9 child victims of maltreatment per 1,000 children under age 18 years in 1997.
Target setting method: 20 percent improvement. (Better than the best will be used when data are available.)
Data source: National Child Abuse and Neglect Data System (NCANDS), Administration on Children, Youth and Families, Administration for Children and Families (ACF), Children's Bureau

15-33b. Reduce child maltreatment fatalities.
Target: 1.5 per 100,000 of children under age 18 years.
Baseline: 1.7 per 100,000 child maltreatment fatalities in 1997.
Target setting method: 12 percent improvement. (Better than the best will be used when data are available.)
Data source: National Child Abuse and Neglect Data System (NCANDS), Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families (ACF).

11. Falls

Injury Prevention
15-27. Reduce deaths from falls.
Target: 2.3 deaths per 100,000 population.
Baseline: 4.5 deaths per 100,000 population were caused by falls in 1998 (preliminary data; age adjusted to the year 2000 standard population).

Target setting method: Better than the best.
Data source: National Vital Statistics System (NVSS), CDC, NCHS.

12. Motor vehicle deaths and hospitalizations

Unintentional Injury Prevention
15-15. Reduce deaths caused by motor vehicle crashes.
Target: 9.0 deaths per 100,000 population for 15-15a and 1 death per 100 million vehicle miles traveled (VMT) for 15-15b.
Baseline: 15.0 deaths per 100,000 population were caused by motor vehicle crashes in 1998 (preliminary data; age adjusted to the year 2000 standard population) for 15-15a and 2 deaths per 100 million VMT were caused by motor vehicle crashes in 1997 for 15-15b.
Target setting method: Better than the best for 15-15a; 50 percent improvement for 15-15b. (Better than the best will be used when data are available.)
Data sources: National Vital Statistics System (NVSS), CDC, NCHS; Federal Highway Administration (FHWA).

15-17. Reduce nonfatal injuries caused by motor vehicle crashes.
Target: 1,000 nonfatal injuries per 100,000 population.
Baseline: 1,270 nonfatal injuries per 100,000 population were caused by motor vehicle crashes in 1997.
Target setting method: 21 percent improvement. (Better than the best will be used when data are available.)
Data source: General Estimates System (GES), DOT, NHTSA.

13. Child passenger safety

Unintentional Injury Prevention
15-20. Increase use of child restraints.
Target: 100 percent.
Baseline: 92 percent of motor vehicle occupants aged 4 years and under used child restraints in 1998 (preliminary data).
Target setting method: Total coverage.
Data source: National Occupant Protection Use Survey (NOPUS), Controlled Intersection Study, DOT, NHTSA.

14. Intentional childhood injuries

Injury Prevention
15-6. (Developmental) Extend State-level child fatality review of deaths due to external causes for children aged 14 years and under.
Potential data sources: National Vital Statistics System (NVSS), CDC, NCHS; Inter-Agency Council on Child Abuse and Neglect (ICAN) National Database, FBI Uniform Crime Report, U.S. Department of Justice.

Death resulting from injury is one of the most profound public health issues facing children in the United States today. In 1997, nearly 19,000 children aged 19 years and under were victims of injury—33 percent from violence and 67 percent from unintentional injury

15-12. Reduce hospital emergency department visits caused by injuries.
Target: 112 hospital emergency department visits per 1,000 population.
Baseline: 130 hospital emergency department visits per 1,000 population were caused by injury in 1997.
Target setting method: Better than the best.
Data source: National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

Total Population, 1997	Injury-Related Hospital Emergency Department Visits
	Rate per 1,000
TOTAL	130
Race and ethnicity	
American Indian or Alaska Native	DSU
Asian or Pacific Islander	DSU
Asian	DSU
Native Hawaiian and other Pacific Islander	DSU
Black or African American	180
White	125
Hispanic or Latino	DSU
Not Hispanic or Latino	DSU
Black or African American	DSU
White	DSU
Gender	
Female	115
Male	145
Education level	
Less than high school	DNC
High school graduate	DNC
At least some college	DNC

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

15. Suicide

Mental Health Status Improvement

18-1. Reduce the suicide rate.
Target: 6.0 suicide deaths per 100,000 population.
Baseline: 10.8 suicide deaths per 100,000 population in 1998 (preliminary data; age adjusted to the year 2000 standard population).
Target setting method: Better than the best.
Data source: National Vital Statistics System (NVSS), CDC, NCHS.

18-2. Reduce the rate of suicide attempts by adolescents.
Target: 12-month average of 1 percent.
Baseline: 12-month average of 2.6 percent among adolescents in grades 9 through 12 in 1997.
Target setting method: Better than the best.
Data source: Youth Risk Behavior Survey (YRBS), CDC, NCCDPHP.

Injury Prevention
15-3. Reduce firearm-related deaths.
Target: 4.9 deaths per 100,000 population.
Baseline: 11.0 deaths per 100,000 population were related to firearm injuries in 1998 (preliminary data; age adjusted to the year 2000 standard population).
Target setting method: Better than the best.
Data source: National Vital Statistics System (NVSS), CDC, NCHS.

15-4. Reduce the proportion of persons living in homes with firearms that are loaded and unlocked.
Target: 16 percent.
Baseline: 19 percent of the population lived in homes with loaded and unlocked firearms in 1998 (preliminary data; age adjusted to the year 2000 standard population).
Target setting method: Better than the best.
Data source: National Health Interview Survey (NHIS), CDC, NCHS.

15-5. Reduce nonfatal firearm-related injuries.
Target: 10.9 injuries per 100,000 population.
Baseline: 26 nonfatal firearm-related injuries per 100,000 population in 1996.
Target setting method: Better than the best.
Data source: National Electronic Injury Surveillance System (NEISS), Consumer Product Safety Commission (CPSC).

16. Homicide

Violence and Abuse Prevention
15-32. Reduce homicides.
Target: 3.2 homicides per 100,000 population.
Baseline: 6.2 homicides per 100,000 population in 1998 (preliminary data; age adjusted to the year 2000 standard population).
Target setting method: Better than the best.
Data sources: National Vital Statistics System (NVSS), CDC, NCHS; Uniform Crime Reports, U.S. Department of Justice, Federal Bureau of Investigation.

17. Teen births

Family Planning
9-7. Reduce pregnancies among adolescent females.
Target: 46 pregnancies per 1,000.
Baseline: 72 pregnancies per 1,000 females aged 15 to 17 years in 1995.
Target setting method: Better than the best.
Data sources: Abortion Provider Survey, Alan Guttmacher Institute; National Vital Statistics System (NVSS), CDC, NCHS; National Survey of Family Growth (NSFG), CDC, NCHS.

18. Unintended pregnancy

Family Planning
9-1. Increase the proportion of pregnancies that are intended.
Target: 70 percent.

Baseline: 51 percent of all pregnancies among females aged 15 to 44 years were intended in 1995.
Target setting method: Better than the best.
Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

9-5. (Developmental) Increase the proportion of health care providers who provide emergency contraception.
Potential data source: Alan Guttmacher Institute.

19. Contraceptive services

Family Planning
9-3. Increase the proportion of females at risk of unintended pregnancy (and their partners) who use contraception.
Target: 100 percent.
Baseline: 93 percent of females aged 15 to 44 years at risk of unintended pregnancies used contraception in 1995.
Target setting method: Total coverage.
Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

Females Aged 15 to 44 Years at Risk of Unintended Pregnancy, 1995	Used Contraception
TOTAL	93%
Race and ethnicity	
American Indian or Alaska Native	DSU
Asian or Pacific Islander	DSU
Asian	DNC
Native Hawaiian and other Pacific Islander	DNC
Black or African American	90%
White	93%
Hispanic or Latino	91%
Not Hispanic or Latino	DNA
Black or African American	90%
White	93%
Age	
15 to 19 years	81%
20 to 24 years	91%
25 to 29 years	94%
30 to 34 years	94%
35 to 39 years	95%
40 to 44 years	93%
Family income level	
Poor	92%
Near poor	91%
Middle/high income	93%
Select populations	
Marital status	
Currently married	95%
Formerly married	92%

Females Aged 15 to 44 Years at Risk of Unintended Pregnancy, 1995	Used Contraception
Never married	88%

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

9-10. Increase the proportion of sexually active, unmarried adolescents aged 15 to 17 years who use contraception that both effectively prevents pregnancy and provides barrier protection against disease.

Target and Baseline:

Objective	Increase in Contraceptive Use at First Intercourse by Unmarried Adolescents Aged 15 to 17 Years	1995 Baseline	2010 Target
	Condom		
9-10a.	Females*	68%	75%
9-10b.	Males	72%	83%
	Condom plus hormonal method		
9-10c.	Females*	6%	9%
9-10d.	Males	8%	11%

Target setting method: Better than the best.
Data sources: Females—National Survey of Family Growth (NSFG), CDC, NCHS; Males—National Survey of Adolescent Males (NSAM), Urban Institute.
*Data currently are collected for females aged 15 to 19 years. Data for females aged 15 to 17 years will be used when available.

20. Abstinence from adolescent sexual activity

Family Planning

9-8. Increase the proportion of adolescents who have never engaged in sexual intercourse before age 15 years.

Target and Baseline:

Objective	Increase in Adolescents Aged 15 to 19 Years Never Engaging in Sexual Intercourse Before Age 15 Years	1995 Baseline	2010 Target
9-8a.	Females	81%	88%
9-8b.	Males	79%	88%

Target setting method: Better than the best.
Data sources: Females—National Survey of Family Growth (NSFG), CDC, NCHS; Males—National Survey of Adolescent Males (NSAM), Urban Institute.

21. First trimester prenatal care

Prenatal Care

16-6. Increase the proportion of pregnant women who receive early and adequate prenatal care.

Target and Baseline:

Objective	Increase in Maternal Prenatal Care	1998 Baseline* (unless noted)	2010 Target
		Percent of Live Births	
16-6a.	Beginning in first trimester of pregnancy	83%	90%
16-6b.	Early and adequate prenatal care	74% (1997)	90%

*Preliminary data.
Target setting method: Better than the best.
Data source: National Vital Statistics System (NVSS), CDC, NCHS.

22. Infant morality

Fetal, Infant, and Child Deaths
16-1. Reduce fetal and infant deaths.
Target and Baseline:

Objective	Reduction in Fetal and Infant Deaths	1997 Baseline	2010 Target
		Per 1,000 Live Births Plus Fetal Deaths	
16-1a.	At 20 or more weeks of gestation	6.8	4.1
16-1b.	During perinatal period (28 weeks of gestation to 7 days or more after birth)	7.5	4.5

Target setting method: Better than the best.
Data source: National Vital Statistics System (NVSS), CDC, NCHS.

Target and Baseline:

Objective	Reduction in Infant Deaths	1998 Baseline*	2010 Target
		Rate per 1,000 Live Births	
16-1c.	All infant deaths (within 1 year)	7.2	4.5
16-1d.	Neonatal deaths (within the first 28 days of life)	4.8	2.9
16-1e.	Postneonatal deaths (between 28 days and 1 year)	2.4	1.5

*Preliminary data
Target setting method: Better than the best.
Data source: National Vital Statistics System (NVSS), CDC, NCHS

Target and Baseline:

Objective	Reduction in Infant Deaths Related to Birth Defects	1998 Baseline* (unless noted)	2010 Target
		Rate per 1,000 Live Births	
16-1f.	All birth defects	1.6	1.1
16-1g.	Congenital heart defects	0.54 (1997)	0.38

*Preliminary data
Target setting method: Better than the best.
Data source: National Vital Statistics System (NVSS), CDC, NCHS.

Target and Baseline:

Objective	Reduction in Infant Deaths Related to Birth Defects	1998 Baseline* (unless noted)	2010 Target
		Rate per 1,000 Live Births	
16-1f.	All birth defects	1.6	1.1
16-1g.	Congenital heart defects	0.54 (1997)	0.38

*Preliminary data

Target setting method: Better than the best.
Data source: National Vital Statistics System (NVSS), CDC, NCHS.

Risk Factors

16-13. Increase the percentage of healthy full-term infants who are put down to sleep on their backs.

Target: 70 percent.
Baseline: 35 percent of healthy full-term infants were put down to sleep on their backs in 1996.
Target setting method: Better than the best.
Data source: National Infant Sleep Position Study, NIH, NICHD.

23. Low birth weight

Obstetrical Care

16-8. Increase the proportion of very low birth weight (VLBW) infants born at Level III hospitals or subspecialty perinatal centers.

Target: 90 percent.
Baseline: 73 percent of VLBW infants were born at Level III hospitals or subspecialty perinatal centers in 1996-97.
Target setting method: 25 percent improvement (better than the best will be used when data are available.)
Data source: Title V Reporting System, HRSA, MCHB.

Risk Factors

16-10. Reduce low birth weight (LBW) and very low birth weight (VLBW).

Target and Baseline:

Objective	Reduction in Low and Very Low Birth Weight	1998 Baseline*	2010 Target
16-10a.	Low birth weight (LBW)	7.6%	5.0%
16-10b.	Very low birth weight (VLBW)	1.4%	0.9%

*Preliminary data.

Target setting method: Better than the best.
Data source: National Vital Statistics System (NVSS), CDC, NCHS.

24. Newborn hearing screening

Hearing

28-11. Increase the proportion of newborns who are screened for hearing loss by age 1 month, have audiologic evaluation by age 3 months, and are enrolled in appropriate intervention services by age 6 months.

Potential data source: State-based Early Hearing Detection and Intervention (EHDI) Program Network, CDC.

25. Breastfeeding initiation and duration

Breastfeeding, Newborn Screening, and Service Systems
16-19. Increase the proportion of mothers who breastfeed their babies.
Target and Baseline:

Objective	Increase in Mothers Who Breastfeed	1998 Baseline	2010 Target
16-19a.	In early postpartum period	64%	75%
16-19b.	At 6 months	29%	50%
16-19c.	At 1 year	16%	25%

Target setting method: Better than the best.
Data source: Mothers' Survey, Abbott Laboratories, Inc., Ross Products Division.

26. Sudden Infant Death Syndrome (SIDS)

Fetal, Infant, and Child Deaths
16-1h. Reduce deaths from sudden infant death syndrome (SIDS).
Target: 0.30 deaths per 1,000 live births.
Baseline: 0.77 deaths per 1,000 live births were from SIDS in 1997.
Target setting method: Better than the best.
Data source: National Vital Statistics System (NVSS), CDC, NCHS.

27. HIV/AIDs

HIV/AIDs
13-1. Reduce AIDS among adolescents and adults.
Target: 1.0 new case per 100,000 persons.
Baseline: 19.5 cases of AIDS per 100,000 persons aged 13 years and older in 1998. Data are estimated; adjusted for delays of AIDS in reporting.
Target setting method: Better than the best.
Data source: HIV/AIDS Surveillance System, CDC, NCHSTP.

13-17. (Developmental) Reduce new cases of perinatally acquired HIV infection.
Potential data source: HIV/AIDS Surveillance System, CDC, NCHSTP.

28. Asthma hospitalizations for children

Respiratory Disease
24-2. Reduce hospitalizations for asthma.
Target and Baseline:

Objective	Age Group	1997 Baseline	2010 Target
		Rate per 10,000	
24-2a.	Children under age 5 years	60.9	25
24-2b.	Children and adults aged 5 to 64 years*	13.8	8
24-2c.	Adults aged 65 years and older*	19.3	10

*Age adjusted to the year 2000 standard population.

Target setting method: Better than the best.
Data source: National Hospital Discharge Survey (NHDS), CDC, NCHS.

24-3. Reduce hospital emergency department visits for asthma.
Target and Baseline:

Objective	Age Group	1995-97 Baseline	2010 Target
		Rate per 10,000	
24-3a.	Children under age 5 years	150.0	80
24-3b.	Children and adults aged 5 to 64 years	71.1	50
24-3c.	Adults aged 65 years and older	29.5	15

Target setting method: Better than the best.
Data source: National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

29. Dental caries

Oral Health
21-1. Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth.
21-1a**.** Reduce the proportion of young children with dental caries experience in their primary teeth.
Target: 11 percent.
Baseline: 18 percent of children aged 2 to 4 years had dental caries experience in 1988-94.
Target setting method: Better than the best.
Data sources: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS; Oral Health Survey of Native Americans, 1999, IHS; California Oral Health Needs Assessment of Children, Dental Heath Foundation, 1993-94.

21-1b. Reduce the proportion of children with dental caries experience either in their primary or permanent teeth.
Target: 42 percent.
Baseline: 52 percent of children aged 6 to 8 years had dental caries experience in 1988-94.
Target setting method: Better than the best.
Data sources: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS; Oral Health Survey of Native Americans, 1999, IHS; California Oral Health Needs Assessment of Children, 1993-94, Dental Health Foundation.

21-1c. Reduce the proportion of adolescents with dental caries experience in their permanent teeth.
Target: 51 percent.
Baseline: 61 percent of adolescents aged 15 years had dental caries experience in 1988-94.
Target setting method: Better than the best.
Data sources: National Health and Nutrition Examination Survey(NHANES), CDC, NCHS; Oral Health Survey of Native Americans, 1999, IHS.

30. Blood lead levels in young children

Toxics and Waste
8-11. Eliminate elevated blood lead levels in children.
Target: Zero children.

Baseline: 4.4 percent of children aged 1 to 5 years had blood lead levels exceeding 10 µg/dL during 1991-94.
Target setting method: Total elimination.
Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

Healthy Homes and Communities
8-22. Increase the proportion of persons living in pre-1950s housing that have tested for the presence of lead-based paint.
Target: 50 percent.
Baseline: 16 percent of persons living in 1998 in homes built before 1950 had tested for the presence of lead-based paint (preliminary data; age adjusted to the year 2000 standard population).
Target setting method: Better than the best.
Data source: National Health Interview Survey (NHIS), CDC, NCHS.

31. Immunizations in young children

Diseases Preventable Through Universal Vaccination
14-1. Reduce or eliminate indigenous cases of vaccine-preventable disease.
Target and Baseline:

Objective	Reduction in Vaccine-Preventable Diseases	1998 Baseline	2010 Target
		Number of Cases	
14-1a.	Congenital rubella syndrome	7	0
14-1b.	Diphtheria (persons under age 35 years)	1	0
14-1c.	*Haemophilus influenzae* type b* (children under age 5 years)	253	0
14-1d.	Hepatitis B (persons aged 2 to 18 years)	945†	9
14-1e.	Measles	74	0
14-1f.	Mumps	666	0
14-1g.	Pertussis (children under age 7 years)	3,417	2,000
14-1h.	Polio (wild-type virus)	0	0
14-1i.	Rubella	364	0
14-1j.	Tetanus (persons under age 35 years)	14	0
14-1k.	Varicella (chicken pox)	4 million‡	400,000

*Includes cases with type b and unknown serotype.
†Estimated hepatitis B cases for 1997.25
‡Data based on average from 1990-94.
Target setting method: Total elimination for congenital rubella syndrome, diphtheria, *Haemophilus influenzae* type b, measles, mumps, polio, rubella, and tetanus; 41 percent improvement for pertussis; 99 percent improvement for hepatitis B; and 99 percent improvement for varicella.
Data sources: National Notifiable Disease Surveillance System (NNDSS), CDC, EPO; National Congenital Rubella Syndrome Registry (NCRSR), CDC, NIP—congenital rubella syndrome; National Health Interview Survey (NHIS), CDC, NCHS—varicella.

32. Overweight and at risk for overweight

Weight Status and Growth
19-3. Reduce the proportion of children and adolescents who are overweight or obese.

Target and Baseline:

Objective	Reduction in Overweight or Obese Children and Adolescents*	1988–94 Baseline†	2010 Target
19-3a.	Aged 6 to 11 years	11%	5%
19-3b.	Aged 12 to 19 years	10%	5%
19-3c.	Aged 6 to 19 years	11%	5%

*Defined as at or above the gender- and age-specific 95th percentile of BMI based on a preliminary analysis of data used to construct the year 2000 U.S. Growth Charts.
Target setting method: Better than the best.
Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

33. Infant and early childhood mental health

None

34. Adolescent mental health

Mental Health Status Improvement
18-1. Reduce the suicide rate.
Target: 6.0 suicide deaths per 100,000 population.
Baseline: 10.8 suicide deaths per 100,000 population in 1998 (preliminary data; age adjusted to the year 2000 standard population).
Target setting method: Better than the best.
Data source: National Vital Statistics System (NVSS), CDC, NCHS

18-2. Reduce the rate of suicide attempts by adolescents.
Target: 12-month average of 1 percent.
Baseline: 12-month average of 2.6 percent among adolescents in grades 9 through 12 in 1997.
Target setting method: Better than the best.
Data source: Youth Risk Behavior Survey (YRBS), CDC, NCCDPHP.

Disabilities and Secondary Conditions
6-2. Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed.
Target: 17 percent.
Baseline: 31 percent of children and adolescents with disabilities were reported to be sad, unhappy, or depressed in 1997.
Target setting method: 45 percent improvement (parity with children and adolescents without disabilities in 1997).
Data source: National Health Interview Survey (NHIS), CDC, NCHS.

Children and Adolescents Under Age 18 Years, 1997	Reported To Be Sad, Unhappy, or Depressed	
	With Disabilities	Without Disabilities*
TOTAL	31%	17%
Race and ethnicity		
American Indian or Alaska Native	DSU	DSU
Asian or Pacific Islander	DSU	13%

Children and Adolescents Under Age 18 Years, 1997	Reported To Be Sad, Unhappy, or Depressed	
	With Disabilities	Without Disabilities*
Asian	DSU	16%
Native Hawaiian and other Pacific Islander	DSU	DSU
Black or African American	DSU	16%
White	31%	17%
Hispanic or Latino	32%	16%
Not Hispanic or Latino	30%	17%
Black or African American	DSU	17%
White	31%	18%
Gender		
Female	32%	16%
Male	30%	18%
Family income level		
Poor	DSU	20%
Near poor	31%	17%
Middle/high income	27%	17%
Geographic location		
Urban	27%	17%
Rural	39%	16%

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.
*The total represents the target. Data for population groups by race, ethnicity, gender, socioeconomic status, and geographic location are displayed to further characterize the issue.

35. Women's mental health/depression

Treatment Expansion
18-6. (Developmental) Increase the number of persons seen in primary health care who receive mental health screening and assessment.
Potential data source: Primary Care Data System/Federally Qualified Health Centers, HRSA.
18-9. Increase the proportion of adults with mental disorders who receive treatment.
Target and Baseline:

Objective	Increase in Adults With Mental Disorders Receiving Treatment	1997 Baseline (unless noted)	2010 Target
18-9a.	Adults aged 18 to 54 years with serious mental illness	47% (1991)	55%
18-9b.	Adults aged 18 years and older with recognized depression	23%	50%
18-9c.	Adults aged 18 years and older with schizophrenia	60% (1984)	75%
18-9d.	Adults aged 18 years and older with anxiety disorders	38%	50%

Target setting method: 17 percent improvement.
Data sources: Epidemiologic Catchment Area (ECA) Program, NIH, NIMH; National Household Survey on Drug Abuse (NHSDA), SAMHSA, OAS; Mental Health U.S., 1996, SAMHSA, CMHS.

36. STIs, chlamydia and gonorrhea

Bacterial STD Illness and Disability

25-1. Reduce the proportion of adolescents and young adults with *Chlamydia trachomatis* infections.

Target and Baseline:

Objective	Reduction in *Chlamydia trachomatis* infections	1997 Baseline	2010 Target
25-1a.	Females aged 15 to 24 years attending family planning clinics	5.0%	3.0%
25-1b.	Females aged 15 to 24 years attending STD clinics	12.2%	3.0%
25-1c.	Males aged 15 to 24 years attending STD clinics	15.7%	3.0%

Target setting method: Better than the best.
Data source: STD Surveillance System, CDC, NCHSTP.

25-2. Reduce gonorrhea.
Target: 19 new cases per 100,000 population.
Baseline: 123 new cases of gonorrhea per 100,000 population in 1997.
Target setting method: Better than the best.
Data source: STD Surveillance System, CDC, NCHSTP.

Personal Behaviors

25-11. Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active.
Target: 95 percent.
Baseline: 85 percent of adolescents in grades 9 through 12 abstained from sexual intercourse or used condoms in 1997 (52 percent had never had intercourse; 13 percent had intercourse but not in the past 3 months; and 20 percent currently were sexually active and used a condom at last intercourse).
Target setting method: 12 percent improvement.
Data source: Youth Risk Behavior Survey (YRBS), CDC, NCCDPHP

37. Fruit and vegetable consumption

Food and Nutrient Consumption

19-5. Increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit.
Target: 75 percent.
Baseline: 28 percent of persons aged 2 years and older consumed at least two daily servings of fruit in 1994-96 (age adjusted to the year 2000 standard population).
Target setting method: Better than the best.
Data source: Continuing Survey of Food Intakes by Individuals (CSFII) (2-day average), USDA.

19-6. Increase the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one-third being dark green or deep yellow vegetables.
Target: 50 percent.

Baseline: 3 percent of persons aged 2 years and older consumed at least three daily servings of vegetables, with at least one-third of these servings being dark green or deep yellow vegetables in 1994-96 (age adjusted to the year 2000 standard population).
Target setting method: Better than the best.
Data source: Continuing Survey of Food Intakes by Individuals (CSFII) (2-day average), USDA.

38. Physical activity

Physical Activity in Children and Adolescents
22-1. Reduce the proportion of adults who engage in no leisure-time physical activity.
Target: 20 percent.
Baseline: 40 percent of adults aged 18 years and older engaged in no leisure-time physical activity in 1997 (age adjusted to the year 2000 standard population).
Target setting method: Better than the best.
Data source: National Health Interview Survey (NHIS), CDC, NCHS.

Adults Aged 18 Years and Older, 1997	No Leisure-Time Physical Activity
TOTAL	40%
Race and ethnicity	
American Indian or Alaska Native	46%
Asian or Pacific Islander	42%
Asian	42%
Native Hawaiian and other Pacific Islander	41%
Black or African American	52%
White	38%
Hispanic or Latino	54%
Not Hispanic or Latino	38%
Black or African American	52%
White	36%
Gender	
Female	43%
Male	36%
Age	
18 to 24 years	31%
25 to 44 years	34%
45 to 64 years	42%
65 to 74 years	51%
75 years and older	65%
Education level (aged 25 years and older)	
Less than 9th grade	73%
Grades 9 through 11	59%
High school graduate	46%
Some college or AA degree	35%
College graduate or above	24%
Geographic location	
Urban	39%

Adults Aged 18 Years and Older, 1997	No Leisure-Time Physical Activity
Rural	43%
Disability status	
Persons with disabilities	56%
Persons without disabilities	36%
Select populations	
Persons with arthritis symptoms	43%
Persons without arthritis symptoms	38%

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.
Note: Age adjusted to the year 2000 standard population.

22-6. Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days.
Target: 30 percent.
Baseline: 20 percent of students in grades 9 through 12 engaged in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days in 1997.
Target setting method: Better than the best.
Data source: Youth Risk Behavior Survey (YRBS), CDC, NCCDPHP.

22-7. Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion.
Target: 85 percent.
Baseline: 64 percent of students in grades 9 through 12 engaged in vigorous physical activity 3 or more days per week for 20 or more minutes per occasion in 1997.
Target setting method: Better than the best.
Data source: Youth Risk Behavior Survey (YRBS), CDC, NCCDPHP.

39. Smoking among pregnant women

Prenatal Substance Exposure
16-17. Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.

Objective	Increase in Reported Abstinence in Past Month From Substances by Pregnant Women*	1996–97 Baseline	2010 Target
16-17a.	Alcohol	86%	94%
16-17b.	Binge drinking	99%	100%
16-17c.	Cigarette smoking†	87%	98%
16-17d.	Illicit drugs	98%	100%

*Pregnant women aged 15 to 44 years.
†Smoking during pregnancy for all women giving birth in 1997 in 46 States, the District of Columbia, and New York City.
Target setting method: Better than the best for 16-17a, and 16-17c; complete elimination for 16-17b and 16-17d.
Data sources: National Household Survey on Drug Abuse, SAMHSA for 16-17a, 16-17b, and 16-17-d. National Vital Statistics System, CDC, NCHS for 16-17c.

27-6. Increase smoking cessation during pregnancy.
Target: 30 percent.
Baseline: 12 percent smoking cessation during the first trimester of pregnancy in 1991 (age adjusted to the year 2000 standard population).
Target setting method: Better than the best.
Data source: National Health Interview Survey (NHIS), CDC, NCHS.

Tobacco
27-6. Increase smoking cessation during pregnancy.
Target: 30 percent.
Baseline: 12 percent smoking cessation during the first trimester of pregnancy in 1991 (age adjusted to the year 2000 standard population).
Target setting method: Better than the best.
Data source: National Health Interview Survey (NHIS), CDC, NCHS.

40. Tobacco use among youth

Tobacco
27-2. Reduce tobacco use by adolescents.
Target and Baseline:

Objective	Reduction in Tobacco Use by Students in Grades 9 Through 12	1997 Baseline	2010 Target
27-2a.	Tobacco products (past month)	43%	21%
27-2b.	Cigarettes (past month)	36%	16%
27-2c.	Spit tobacco (past month)	9%	1%
27-2d.	Cigars (past month)	22%	8%

Target setting method: Better than the best.
Data source: Youth Risk Behavior Survey (YRBS), CDC, NCCDPHP.

27-4. Increase the average age of first use of tobacco products by adolescents and young adults.
Target and Baseline:

Objective	Increase in Average Age of First Tobacco Use	1997 Baseline	2010 Target
		Average Age of First Use in Years	
27-4a.	Adolescents aged 12 to 17 years	12	14
27-4b.	Young adults aged 18 to 25 years	15	17

Target setting method: Better than the best.
Data source: National Household Survey on Drug Abuse (NHSDA), SAMHSA.

41. Alcohol use

Substance Use and Abuse
26-9. Increase the age and proportion of adolescents who remain alcohol and drug free.
Target and Baseline:

Objective	Increase Average Age of First Use in Adolescents Aged 12 to 17 Years	1997 Baseline	2010 Target
		Average Age in Years	
26-9a.	Alcohol	13.1	16.1
26-9b.	Marijuana	13.7	17.4

Target setting method: Better than the best for alcohol use; consistent with Office of National Drug Control Policy for marijuana use.
Data source: National Household Survey on Drug Abuse (NHSDA), SAMHSA.

26-11. Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.
Target and Baseline:

Objective	Reduction in Students Engaging in Binge Drinking During Past 2 Weeks	1998 Baseline	2010 Target
26-11a.	High school seniors	32%	11%
26-11b.	College students	39%	20%

Target setting method: Better than the best.
Data source: Monitoring the Future Study, NIH, NIDA.

42. New parent home visitation

None.

43. Folic acid knowledge and use

Risk Factors
16-15. Reduce the occurrence of spina bifida and other neural tube defects (NTDs).
Target: 3 new cases per 10,000 live births.
Baseline: 6 new cases of spina bifida or another NTD per 10,000 live births in 1996.
Target setting method: 50 percent improvement (better than the best will be used when data are available).
Data source: National Birth Defects Prevention Network (NBDPN), CDC, NCEH.

16-16. Increase the proportion of pregnancies begun with an optimum folic acid level.
Target and Baseline:

Objective	Increase in Pregnancies Begun With Optimum Folic Acid Level	1991–94 Baseline*	2010 Target
		Percent	
16-16a.	Consumption of at least 400 µg of folic acid each day from fortified foods or dietary supplements by nonpregnant women aged 15 to 44 years	21	80
		Number	
16-16b.	Median RBC folate level among nonpregnant women aged 15 to 44 years	161 ng/ml	220 ng/ml

*Preliminary estimate.
Target setting method: Better than the best.
Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

44. Comprehensive, coordinated school health programming

Educational and Community-Based Programs
7-2. Increase the proportion of middle, junior high, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use;

unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health.

Target and Baseline:

Objective	Schools Providing Comprehensive School Health Education in Priority Areas	1994 Baseline	2010 Target
7-2a.	**Summary objective** (all components)	28%	70%
	Specific objectives (components to prevent health problems in the following areas):		
7-2b.	Unintentional injury	66%	90%
7-2c.	Violence	58%	80%
7-2d.	Suicide	58%	80%
7-2e.	Tobacco use and addiction	86%	95%
7-2f.	Alcohol and other drug use	90%	95%
7-2g.	Unintended pregnancy, HIV/AIDS, and STD infection	65%	90%
7-2h.	Unhealthy dietary patterns	84%	95%
7-2i.	Inadequate physical activity	78%	90%
7-2j.	Environmental health	60%	80%

Target setting method: 150 percent improvement.

Data source: School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

November 2004

Related Objectives - Healthiest Wisconsin 2010 to the 44 Maternal and Child Health Potential Needs

1. Access to health care for children

Access to Primary and Preventive Health Services

Objective 4: Access to Oral Health Services

Not provided

By 2010, increase by 10 percent the proportion of each of the following populations who receive ongoing preventive and restorative oral health care: Medicaid/BadgerCare, uninsured and underinsured populations.

Objective 4	Access to Oral Health Services
Long-Term Objective	By 2010, increase by 10 percent the proportion of each of the following populations who receive ongoing preventive and restorative oral health care: Medicaid/BadgerCare, uninsured and underinsured populations.
Baseline	Not provided

2. Health insurance coverage

Access to Primary and Preventive Health Services

Objective 1	Increase Percentage of the Population with Health Insurance
Long-Term Objective	By 2010, increase to 92 percent, the proportion of the population with health insurance for all of the year.
Baseline	88% in 2000
Data Source	Wisconsin Family Health Survey Insurance Coverage 2000 (DHFS, DPH, Bureau of Health Information and Policy).

3. CSHCN and families partner in decision making and satisfied with services

4. CSHCN receive care within a Medical Home

5. CSHCN have adequate insurance

6. CSHCN and families access to community services

7. Youth with SHCN transition to adulthood

8. CSHCN access to dental care

9. Unintentional childhood injuries

10. Child abuse and neglect

Intentional and Unintentional Injuries and Violence

Objective 1	Prevention of Child Maltreatment
Long-Term Objective	By 2010, there will be a 10 percent reduction in the number of children who are abused and neglected in Wisconsin as reported by the Department of Health and Family Services and other appropriate governmental data sources.
Baseline	While measurement issues make it difficult to identify a baseline figure, some possible measures include: 27.8 reports per 1,000 population (ages 17 and under). A total of 38,010 maltreatment reports were filed in Wisconsin in 2000. 26.7% maltreatment substantiation rate 10 substantiated cases of a child having died from maltreatment
Data Source	2000 data, Annual Report to the Governor and Legislature on Wisconsin Child Abuse and Neglect, Office of Policy, Evaluation and Planning, Division of Children and Family Services, Department of Health and Family Services.

11. Falls

Intentional and Unintentional Injuries and Violence

Objective 3a	
Long-Term Objective	By 2010, the age adjusted fall death rate will be 9.0/100,000 population.
Baseline	In 2000, the Wisconsin's age adjusted fall death rate was 10.8/100,000 population.
Data Source	WISQARS Injury Mortality Report, 2000

Objective 3b	
Long-Term Objective	By 2010, hospitalizations from falls will decrease to 22.5%.
Baseline	In 2000, 25% of all hospitalizations were due to falls. In 2000, 87% of all fall deaths were in the 65+ age groups. In 2000, 73% of all fall related hospitalizations were in the age groups 65+.
Data Source	Wisconsin Department of Health and Family Services, Division of Public Health Care Financing, Bureau of Health Information and Policy, WISH Query System, 2004

12. Motor vehicle deaths and hospitalizations

Intentional and Unintentional Injuries and Violence

Objective 2a	
Long-Term Objective	By 2010, the rate of motor vehicle crash-related deaths and incapacitating injuries will be 104 per 100,000 population.
Baseline	Rate of motor vehicle crash-related deaths and serious injuries was 135 per 100,000 population in 2000. In 2000, there were a total of 43,145 injury crashes, 718 of these were fatal. In 2000, there were a total of 1,657 pedestrian crashes, 50 of these were fatal. In 2000, there were a total of 9,096 alcohol-related

crashes, 301 of these were fatal. 36 work-related deaths from motor vehicle related crashes. 30% of all work-related fatalities.

Data Source Department of Transportation Five Year Summary of Motor Vehicle Crashes – July 2002. Department of Transportation Drivers and Vehicles Final Year Crash Statistics (2002 crash statistics with comparison to prior years).

13. Child passenger safety

14. Intentional childhood injuries

15. Suicide

16. Homicide

17. Teen births

18. Unintended pregnancy

<u>High Risk Sexual Behavior</u>

Objective 2 Unintended Pregnancy in Wisconsin
Long-Term Objective By 2010, 30% or fewer of pregnancies to Wisconsin residents will be unintended.
Baseline 34.5% of pregnancies in Wisconsin are unintended.
Data Source 2000 Wisconsin Behavioral Risk Factor Survey (DHFS, DPH, BHIP). Measure: Question on most recent pregnancy.

19. Contraceptive services

20. Abstinence from adolescent sexual activity

<u>High Risk Sexual Behavior</u>

Objective 1a
Long-Term Objective By 2010, 30% or fewer of Wisconsin high school youth report ever having sexual intercourse.
Baseline In 1993, 47% reported ever having had sexual intercourse. In 1999, 41% reported ever having had sexual intercourse. In 2001, 39% reported ever having had sexual intercourse.
Data Source Wisconsin Youth Risk Behavioral Survey

21. First trimester prenatal care

22. Infant mortality

23. Low birth weight

24. Newborn hearing screening

25. Breastfeeding initiation and duration

Adequate and Appropriate Nutrition

Objective 2b

Long-Term Objective	By 2010, increase the proportion of mothers who initiate breastfeeding their infants in the hospital to 80 percent
Baseline	Breastfeeding: In hospital: 67.7%; at 6 months: 37.7%; at 12 months: not available.
Data Source	2000 Ross Mothers' Survey, Abbott Laboratories, Ross Products Division

26. Sudden Infant Death Syndrome (SIDS)

27. HIV/AIDS

High Risk Sexual Behavior

Objective 3d

Long-Term Objective	By the year 2010 the incidence of human immunodeficiency virus (HIV) infection in Wisconsin will be 2.5 cases per 100,000 population.
Baseline	4.9 diagnosed cases of HIV infection per 100,000 population in Wisconsin during 1999.
Data Source	Wisconsin AIDS/HIV Quarterly Surveillance Summary, Cases reported through December 31, 2003, Table 1b (diagnosed cases). p 1. (DHFS, DPH, BCDP)

28. Asthma hospitalizations for children

Access to Primary and Preventive Health Services

Objective 2a

Long-Term Objective	Reduce preventable hospitalizations for ambulatory-care-sensitive conditions – pediatric asthma, diabetes, and pneumonia in persons 65 and older.
Baseline	Hospitalization rates for the following first-listed discharge diagnoses: asthma (children), diabetes (all ages), pneumonia, (age 65+).
Data Source	WI hospitalization in-patient data files (DHFS, DPH, Bureau of Health Information and Policy).

29. Dental caries

30. Blood lead levels in young children

Environmental and Occupational Health Hazards

Objective
Long-Term Objective

Baseline	The national childhood lead poisoning average, at this time, is approximately 2.2% and declining, while Wisconsin's rate among those children tested is 6.1%.
Data Source	WI lead reporting system

31. Immunizations in young children

Existing, Emerging, and Re-emerging Communicable Disease

Objective 2a

Long-Term Objective	By 2010, at least 90% of Wisconsin residents under two years of age will be fully immunized in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.

32. Overweight and at risk for overweight

Overweight, Obesity, Lack of Physical Activity

Objective 4a

Long-Term Objective	Between 2000 and 2010, reduce the proportion of Wisconsin children who are overweight from 11.4 percent to 9.4 percent.
Baseline	11.4% of children > 2 years and < 5 years are overweight, based on the 2000 CDC growth chart percentiles for BMI-for-age for children 2 years and older.
Data Source	2000 Wisconsin Pediatric Nutrition Surveillance Report, Centers for Disease Control and Prevention (DHFS, DPH, BCHP).

Objective 4b

Long-Term Objective	Between 2001 and 2010, reduce the proportion of Wisconsin adolescents who are overweight from 10 percent to 8 percent.
Baseline	10% of adolescents aged 12 to 19 years were overweight, based on the 2000 CDC growth chart percentiles for BMI-for-age for children 2 years and older.
Data Source	2001 Wisconsin Youth Risk Behavior Survey (DPI).

33. Infant and early childhood mental health

34. Adolescent mental health

35. Women's mental health/depression

36. STIs, chlamydia and gonorrhea

High Risk Sexual Behavior

Objective 3b

Long-Term Objective	By the year 2010 the incidence of genital Chlamydia trachomatis infection in Wisconsin will be 138 cases per 100,000 population.
Baseline	275.4 cases of genital Chlamydia trachomatis infection per 100,000 population in Wisconsin during 1999.
Data Source	Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2001. Atlanta, GA: US Department of Health and Human Services, Sept. 2002. Table 4, p85.

Objective 3c

Long-Term Objective By the year 2010 the incidence of Neisseria gonorrheae infection in Wisconsin will be 63 cases per 100,000 population.
Baseline 126.9 cases of Neisseria gonorrheae infection per 100,000 population in 1999.
Data Source Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2001. Atlanta, GA: US Department of Health and Human Services, Sept. 2002. Table 14, p97.

Objective 3d
Long-Term Objective By the year 2010 the incidence of human immunodeficiency virus (HIV) infection in Wisconsin will be 2.5 cases per 100,000 population.
Baseline 4.9 diagnosed cases of HIV infection per 100,000 population in Wisconsin during 1999.
Data Source Wisconsin AIDS/HIV Quarterly Surveillance Summary, Cases reported through December 31, 2003, Table 1b (diagnosed cases). p 1. (DHFS, DPH, BCDP)

37. Fruit and vegetable consumption

38. Physical activity

Overweight, Obesity, Lack of Physical Activity

Objective 2
Long-Term Objective Physical Activity for Children and Adolescents Between 2001 and 2010, increase the proportion of Wisconsin adolescents who report they engaged in at least 30 minutes of moderate physical activity, on five or more of the previous seven days, from 27 percent to 37 percent.
Baseline 27 % of student in grades 9 through 12 engaged in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days.
Data Source Wisconsin Youth Risk Behavior Surveillance System, Centers for Disease Control and Prevention, 2001 (Dept of Public Instruction).

39. Smoking and pregnant women

40. Tobacco use among youth

Tobacco Use and Exposure

Objective 1a
Long-Term Objective Tobacco use among Wisconsin middle school youth will decrease from 16% in 2000 to 12% in 2010.
Baseline See list
Data Source Definitive Measure: Wisconsin Youth Tobacco Survey, 2000. Additional Measures: Wis Youth Risk Behavioral Survey, 1999, DPI, Great Lakes Inter-Tribal Council Youth Tobacco Survey, 2000 Bureau of Substance Abuse Services, Division of Supportive Living. As of July 2003, the source for Synar data is: Bureau of Community Health and Prevention.

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41. Alcohol use

42. New parent home visitation

43. Folic acid knowledge and use

44. Comprehensive coordinates school health programming

Related Title V National and State Performance Measures to the 44 Maternal and Child Health Potential Needs

1. Access to health care for children

State Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
SPM 1. Percent of children less than 12 years of age who receive one physical exam a year.	X		74.4.6%	79.0%		N

2. Health insurance coverage

National Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Object ive met Y	Object ive met N
NPM 13. Percent of children without health insurance.	X		2.6%	4.5%	Y	

3. CSHCN and families partner in decision making and satisfied with services

National Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
NPM 2. Percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.		X	66.6%	67.6%		N - almost

4. CSHCN receive care within a Medical Home

National Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
NPM 3. Percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.		X	57.1%	58.1%		N- almost

5. CSHCN have adequate insurance

National Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
NPM 4. Percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.		X	66.6%	66.6%	Y	

6. CSHCN and families access to community services

National Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
NPM 5. Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.		X	80.7%	81.7%		N - almost

7. Youth with SHCN transition to adulthood

National Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
NPM 6. Percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life.		X	7.5%	6.8%		N - almost

8. CSHCN access to dental care

9. Unintentional childhood injuries

10. Child abuse and neglect

11. Falls

12. Motor vehicle deaths and hospitalizations

National Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
NPM 10. Rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.	X		3.5	3.8	Y	
State Performance Measure	**Data Year 02**	**Data Year 03**	**Indicator**	**Objective**	**Objective met Y**	**Objective met N**
SPM 9. Death rate per 100,000 among youth ages 15-19, due to motor vehicle crashes.	X		28.1	27.5		N – almost

13. Child passenger safety

14. Intentional childhood injuries

15. Suicide

National Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
NPM 16. Rate (per 100,000) of suicide deaths among youths aged 15 through 19.	X		10.5	7.0		N

16. Homicide

17. Teen births

National Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
NPM 8. Rate of birth (per 1,000) for teenagers aged 15 through 17 years.	X		16	18.5	Y	

18. Unintended pregnancy

State Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
SPM 2. Percent of women at risk of unintended		X	42.9%	19.0%	Y	

pregnancies (as defined by Alan Guttmacher Institute) receiving family planning and related reproductive health services through publicly funded clinics.						

19. Contraceptive services

20. Abstinence from adolescent sexual activity

21. First trimester prenatal care

National Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
NPM 18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	X		84.2%	84.2%	Y	N

22. Infant mortality

State Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
SPM 8. Ratio of the black infant mortality rate to the white infant mortality rate.	X		3.3	2.5		N

23. Low birth weight

National Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
NPM 15. Percent of very low birth weight infants among all live births.	X		1.3%	1.0%		N
NPM 17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.	X		68.6%	81.4%		N

24. Newborn hearing screening

National Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
NPM 12. Percentage of newborns who have been screened for hearing before hospital discharge.		X	94.5%	93.0%	Y	

25. Breastfeeding initiation and duration

National Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
NPM 11. Percentage of mothers who breastfeed their infants at hospital discharge.	X		73.0%	68.0%	Y	

State Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
SPM 5. Percent of women enrolled in WIC during pregnancy who initiated breastfeeding.	X		59.2%	59.0%	Y	

26. Sudden Infant Death Syndrome (SIDS)

27. HIV/AIDs

28. Asthma hospitalization for children

29. Dental caries

National Performance Measure	Data Year 02 / 03		Indicator	Objective	Objective met Y / N	
NPM 9. Percent of third grade children who have received protective sealants on at least one permanent molar tooth.		X	47.0%	49.0%		N

State Performance Measure	Data Year 02 / 03		Indicator	Objective	Objective met Y / N	
SPM 6. Percent of children, ages 6-8, with untreated dental decay in primary and permanent teeth.		X	30.8%	30.0%		N

30. Blood lead levels in young children

31. Immunizations in young children

National Performance Measure	Data Year 02 / 03		Indicator	Objective	Objective met Y / N	
NPM 7. Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.		X	82.6%	79.0%	Y	

32. Overweight and at risk for overweight

State Performance Measure	Data Year 02 / 03		Indicator	Objective	Objective met Y / N	
SPM 7. Percent of children, ages 2-4, who are overweight.	X		11.8%	11.2%		N – almost

33. Infant and early childhood mental health

34. Adolescent mental health

National Performance Measure	Data Year 02 / 03		Indicator	Objective	Objective met Y / N	
NPM 16. Rate (per 100,000) of suicide deaths among youths aged 15 through 19.	X		10.5	7.0		N

35. Women's mental health/depression

36. STIs, chlamydia, gonorrhea

37. Fruit and vegetable consumption

38. Physical activity

39. Smoking among pregnant women

State Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
SPM 3. Percent of women who use tobacco during pregnancy.	X		14.8%	16.0%	Y	

40. Tobacco use among youth

41. Alcohol use

State Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
SPM 4. Percent of high school youth who self-report taking a drink in the past 30 days.		X	47.9%	45.0%		N

42. New parent home visitation

State Performance Measure	Data Year 02	Data Year 03	Indicator	Objective	Objective met Y	Objective met N
SPM 10. Percent of MCH clients/families who receive one or more supportive services to enhance child health, development and/or safety.		X	73.7%	75.0%		N - almost

43. Folic acid knowledge and use

44. Comprehensive coordinated school health programming

Title V MCH Needs Assessment

Stakeholder Training
November 1, 2004

Stakeholder Training Agenda

- Overview of Needs Assessment Process
- Review of MCH Identified Needs
- Using the Q-sort methodology to rank priorities
- Q-Sort Data Analysis
- Consensus building, set priorities, identify solutions and strategies
- State performance measures, program direction and allocate resources
- Questions and wrap-up

Handouts for Training

- Agenda
  - Instructions for using the Q Sort Technique
  - Q Sort Priority Log
- Maternal and Child Health Potential Needs
- Copy of 44 squares
- Example of data detail sheet
  - # 39 Smoking among pregnant women
- Q Sort Priority Log (for filling out)

Presenters

- Linda Spaans Esten - State SSDI Coordinator
- Elizabeth Oftedahl - CSHCN Epidemiologist
- Kate Kvale - MCH Epidemiologist
- Randy Glysch - Research Scientist, Injury Program
- Dan Miner-Nordstrom - UW Wisconsin
  - Masters Candidate, UW School of Social Work
  - WI MCH LEND Program
- Susan Kratz - SPHERE State Coordinator
- Susan Uttech - Chief, Family Health Section

Title V MCH Needs Assessment

- Federal Requirement
  - Title V of the Social Security Act
    - In 1935, President Roosevelt signed legislation into law to promote and improve maternal and child health
  - WI Dept of Health Family Services, Division of Public Health (DPH)
    - receives funds through the federal Maternal and Child Health (MCH) Services Block Grant
  - Required statewide needs assessment every 5 years
    - In 1990s greater sophistication in assessing unmet needs
    - Increased accountability in measuring program performance

MCH Needs Assessment Purpose

- Direct decisions toward the most appropriate programs and policies that promote the health of women, children, CSHCN and their families.
- Needs assessment is a fundamental element of program planning
- Needs assessment is about CHANGE

MCH Needs Assessment is part of an ongoing cycle

- Assess problems, needs, assets & strengths
- Develop and implement solutions
- Evaluate activities
- Monitor performance

Title V MCH Needs Assessment

- We undertake needs assessment because:
  - We recognize the dynamic nature of MCH
  - We wish to be good stewards of the public's trust
  - We must set priorities within limited resources

MCH Needs Assessment

- Should be data driven and engage stakeholders
- Process must bridge:
  - Science and politics
  - Data and values of the community
  - Needs and the strategies for their solution

Stakeholders

- Needs assessments must engage and involve the community of interest, the stakeholders
  - Understand the values of the community
  - Know the needs
  - Help to identify strategies and solutions

Who are the stakeholders?

- Local Health Departments (LHDS)
- Regional CSHCN Centers
- Family Planning/Reproductive Health
- Professional organizations
- Advocacy organizations
- Parents
- Professional staff from hospitals/clinics
- Minority health
- Division of public health
- Department of Public Instruction

Needs Assessment is data driven

- Population based data
  - Census, Vital Records
- Surveillance systems data
  - SLAITS, BRFSS, YRBS, PedNSS, communicable disease incidence
- Survey data from Family Health Survey
- Program and service data
- Listening Sessions

MCH Identified Needs

- 44 Identified Needs
  - 16 Listening sessions reaching 350 people
  - Federal MCH needs
  - State and local identified MCH needs
- Data detail sheet developed for each need
- Packets of data detailed sheets mailed week of November 1, 2004

Maternal and Child Health Potential Needs

1. Access to health care for children
2. Health insurance coverage
3. CSHCN & families partner in decision making and satisfied with services
4. CSHCN receive care within a Medical Home
5. CSHCN have adequate insurance
6. CSHCN & families access to community services
7. Youth with SHCN transition to adulthood
8. CSHCN access to dental care
9. Unintentional childhood injuries
10. Child abuse and neglect
11. Falls
12. Motor vehicle deaths and hospitalizations
13. Child passenger safety
14. Intentional childhood injuries
15. Suicide
16. Homicide
17. Teen births
18. Unintended pregnancy
19. Contraceptive services
20. Abstinence from adolescent sexual activity
21. First trimester prenatal care
22. Infant mortality
23. Low birth weight
24. Newborn hearing screening
25. Breastfeeding initiation and duration
26. Sudden Infant Death Syndrome (SIDS)
27. HIV/AIDS
28. Asthma hospitalization for children
29. Dental caries
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32. Overweight and at risk for overweight
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35. Women's mental health/depression
36. STIs, chlamydia and gonorrhea
37. Fruit and vegetable consumption
38. Physical activity
39. Smoking among pregnant women
40. Tobacco use among youth
41. Alcohol use
42. New parent home visitation
43. Folic acid knowledge and use
44. Comprehensive coordinated school health programming

#39 *Smoking among pregnant women*

DEFINITION

Percent of women who reported smoking during pregnancy. The age of the women is 18-44 years (women of reproductive age) but may include women younger or older as reported on the birth certificate.

DESCRIPTION OF THE NEED

Overall in 2002, 10,139 or 15% of pregnant women reported smoking during pregnancy [(1)]. In terms of racial differences, Native American women continue to report the highest percentage of smoking during pregnancy, nearly three times as high as the overall state percentage.

Smoking during pregnancy is harmful to the fetus, and smoking can cause complications during pregnancy such as miscarriage, stillbirth, impaired placental function, intrauterine growth retardation, and preterm delivery [(2)]. One of the most well known consequences of smoking during pregnancy is low birth weight [(3)].

NATIONAL / STATE GOAL

Healthy People 2010 Health Objective(s):

27-6: Increase smoking cessation during pregnancy

Healthiest Wisconsin 2010 Health Priority:

Tobacco Use and Exposure

Title V State Performance Measure:

Percent of women who used tobacco during pregnancy

DATA DEPICTION

Using Q Sort Technique to select priorities

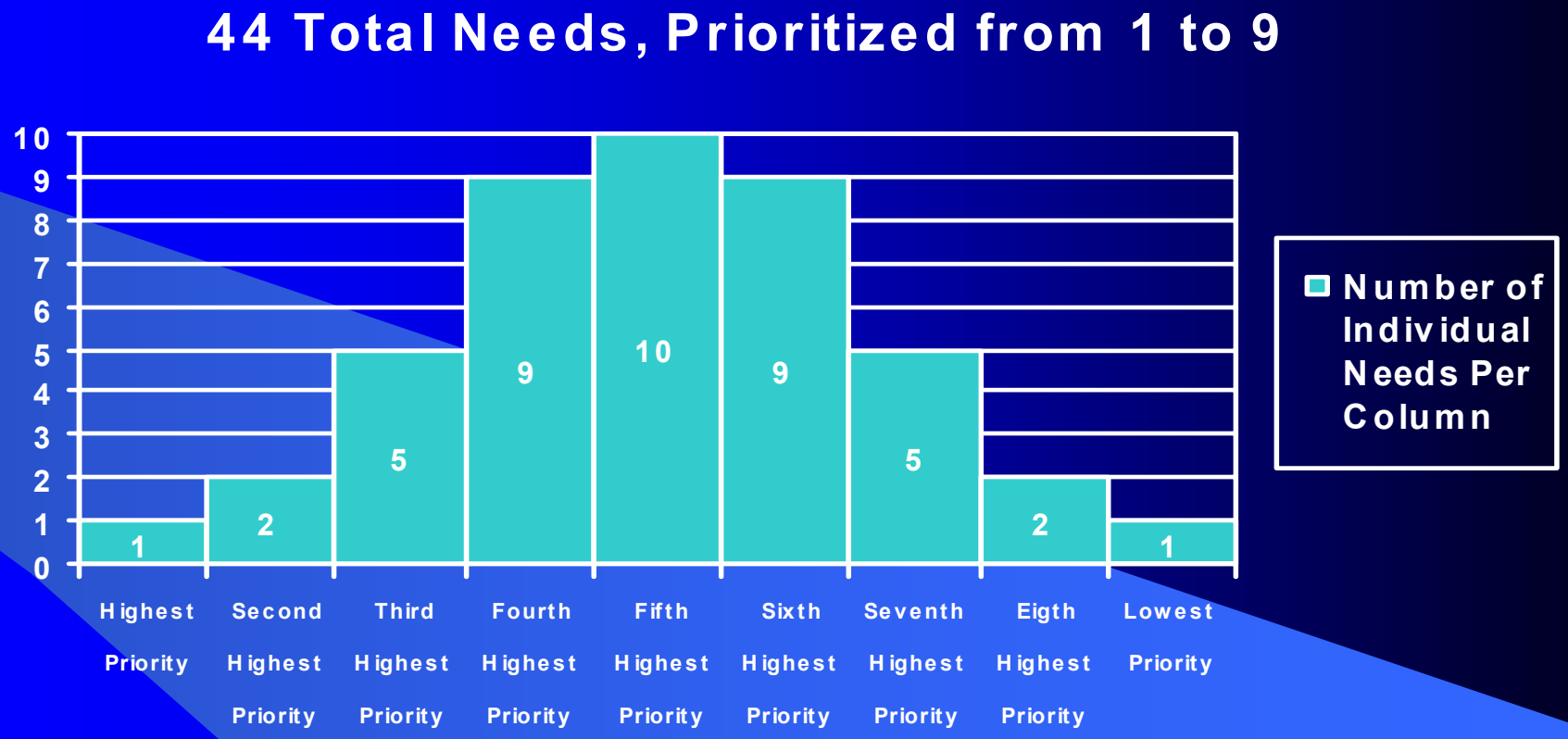
- Purpose: To identify priorities among competing needs
- Stakeholders have unique expertise, perspectives and passions about needs
- All needs cannot be the “highest priority” for the state MCH program
- Q Sort Technique is effective at getting information from people with different backgrounds

Brief History of Q-Sort Methodology

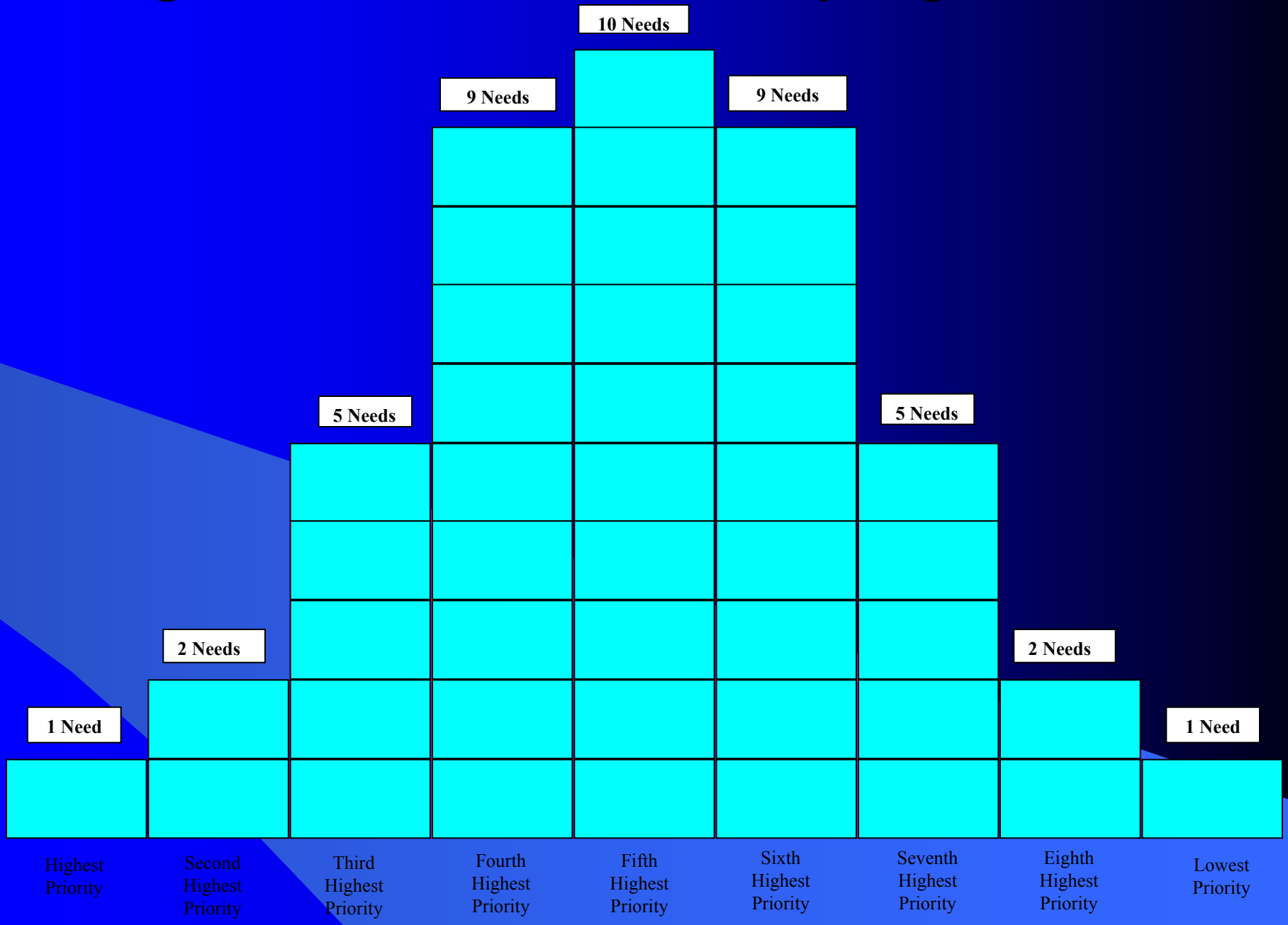
- Developed in 1935 by British physicist-psychologist William Stephenson
- Associated with quantitative analysis due to involvement with multiple factor analysis
- Reveals subjectivity involved in a situation

What should the table look like?

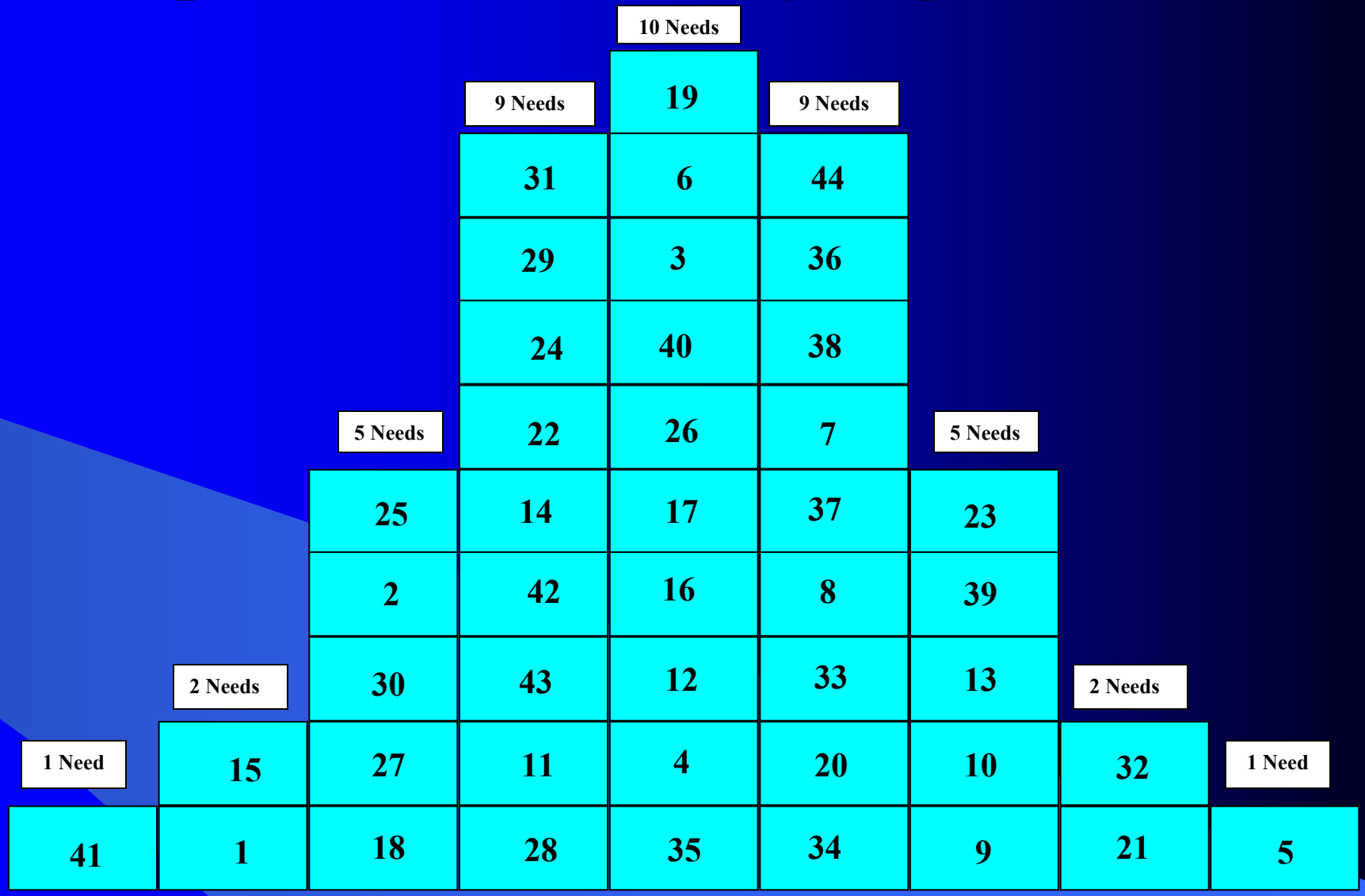
- Create Nine Columns



Inserting Needs on the Q-Sort Priority Log



Completed Q-Sort Priority Log



How will these data be analyzed?

- Look at the mean score of each need after gathering responses.
- Scores will be assessed for their variability by using the standard deviation.
- Some scores may be weighted if they are from under-represented fields or regions.

Scoring and Standard Deviation

- If *Health Insurance Coverage for Children* rates a score of 2.5 and has a very small standard deviation, you know that most everyone agreed this was a high priority
- Conversely, if *Unintended Pregnancy* also rated high at 2.5, but had a large standard deviation, you know some rated it high while others rated it low

Where to Get More Information on the Q-Sort Method

- Detailed information on the Q-Sort Method can be found at http://www.qmethod.org

Next Steps: After Q Sort……

Consensus building

Our needs assessment process is not done until we:

- Set priorities
- Identify solutions and strategies
- Determine Wisconsin's State Performance Measures for the federal Title V Block Grant Application
- Determine program direction, and
- Allocate available resources

In January 2005

We will invite a smaller group of stakeholders to a face-to-face meeting to help us:

- Establish priorities
- Identify solutions and strategies

Things to Consider
(to bring a method to the madness)

- Reach consensus and set priorities
  - Size of problem: extent, number
  - Seriousness of problem: urgency, severity, economic loss, impact on population
  - Availability and effectiveness of interventions
  - Economic feasibility
  - Acceptability of intervention by public
  - Legal and/or political issues

Things to Consider
(to bring a method to the madness)

- Identify solutions and strategies to:
  - Determine whether or not we can do anything about the need and what precisely it is we can and wish to do.

Generate possible solutions related to a priority

- Compare the priority to strategies such as
  - Provide service directly
  - Contract with others to provide service
  - Provide education to public and/or providers
  - Systems development
  - Data system improvement

Generate possible solutions related to priority

- Then ask the following questions for each strategy:
  - How effective would this solution be?
    - Low, medium, high
  - How efficient would this solution be?
    - Low, medium, high
  - How acceptable would this solution be?
    - Low, medium, high

Determine Wisconsin's Title V State Performance Measures

- Compile results and internally finalize recommendations for
  - State Performance Measures
  - Program Direction
  - Resource Allocation
- Present findings to Department
- Include final recommendations for annual Title V Block Grant Application

Stakeholder responsibility

- Review the data detail packets
- Use the Q-sort method to prioritize the 44 needs
- Complete the Priority Log
  - Insert 44 numbers in the boxes
  - Provide demographic data (required/optional)
  - Add (optional) additional high priority

Return priority log by December 8, 2004

- Mail or email to Jayne McCredie
  - 1 West Wilson Street-Room 351, Madison, WI 53702
  - Mccrejh@dhfs.state.wi.us
- Questions about the process?
  - Email Linda Spaans Esten
  - Spaanln@dhfs.state.wi.us

View archive of this presentation

- Archive will be on the web for 2 weeks
- All stakeholders will receive the URL address for viewing the archived presentation

QUESTIONS FOR PRESENTERS?

Title V MCH Needs Assessment

SETTING PRIORITIES

March 30, 2005

Agenda

- Overview of Needs Assessment Process
- Using the Q-sort methodology to rank priorities
- Results of Q-Sort Data Analysis
- National & State Performance Measures
- WI 2010 Health Priorities
- Process for Setting Priorities
- Consensus Building
- Small group discussion
- Overview and wrap-up

Handouts for Meeting

- Agenda
- List of attendees and group assignments
- Q-Sort Results (goldenrod)
- Q-Sort Needs Grid (blue)
- Health Problem Priority Setting Worksheet (green)
- Q-Sort Rank by population group (colored print)
- Consensus Definition (yellow)
- Enhanced Data Detail Sheets (20 top ranked)

Presenters

- Linda Spaans Esten - State SSDI Coordinator
- Randy Glysch - Research Scientist, Injury Program
- Kate Kvale - MCH Epidemiologist
- Elizabeth Oftedahl - CSHCN Epidemiologist
- Murray Katcher - BCHP Chief Medical Officer
- Susan Uttech - Chief, Family Health Section

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- Survey data from Family Health Survey
- Program and service data
- Listening Sessions

MCH Identified Problems/Needs

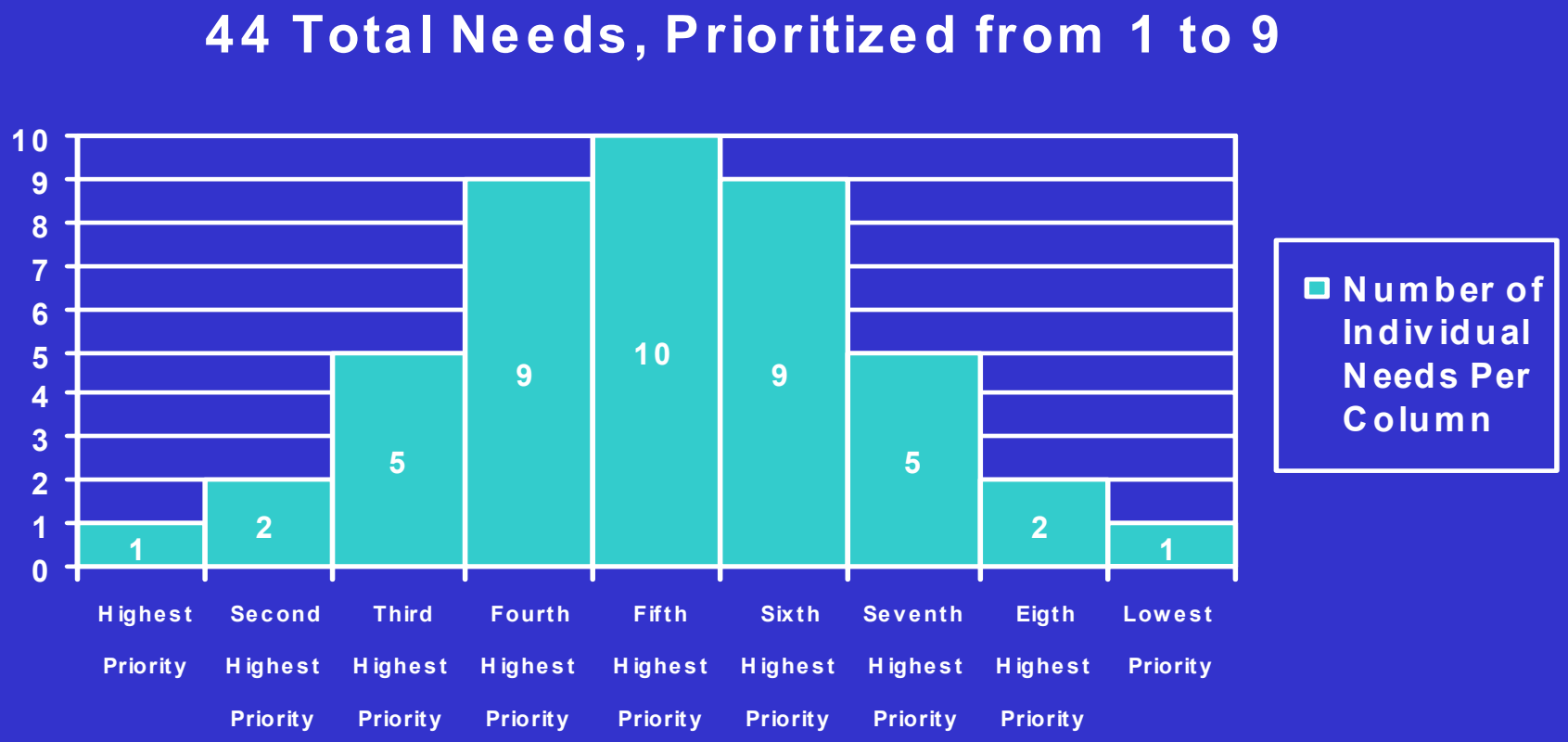
- 44 Identified Needs
  - 16 Listening sessions reaching 350 people
  - Federal MCH needs
  - State and local identified MCH needs
- Developed data detail sheet for each need
- Invited 200 people to participate as stakeholders
- Distributed 90 packets of data detail sheets in November 2004
- Held a stakeholder Q- Sort Training
- Participation by 61 stakeholders in Q-sort process

Used Q Sort Technique to select priorities

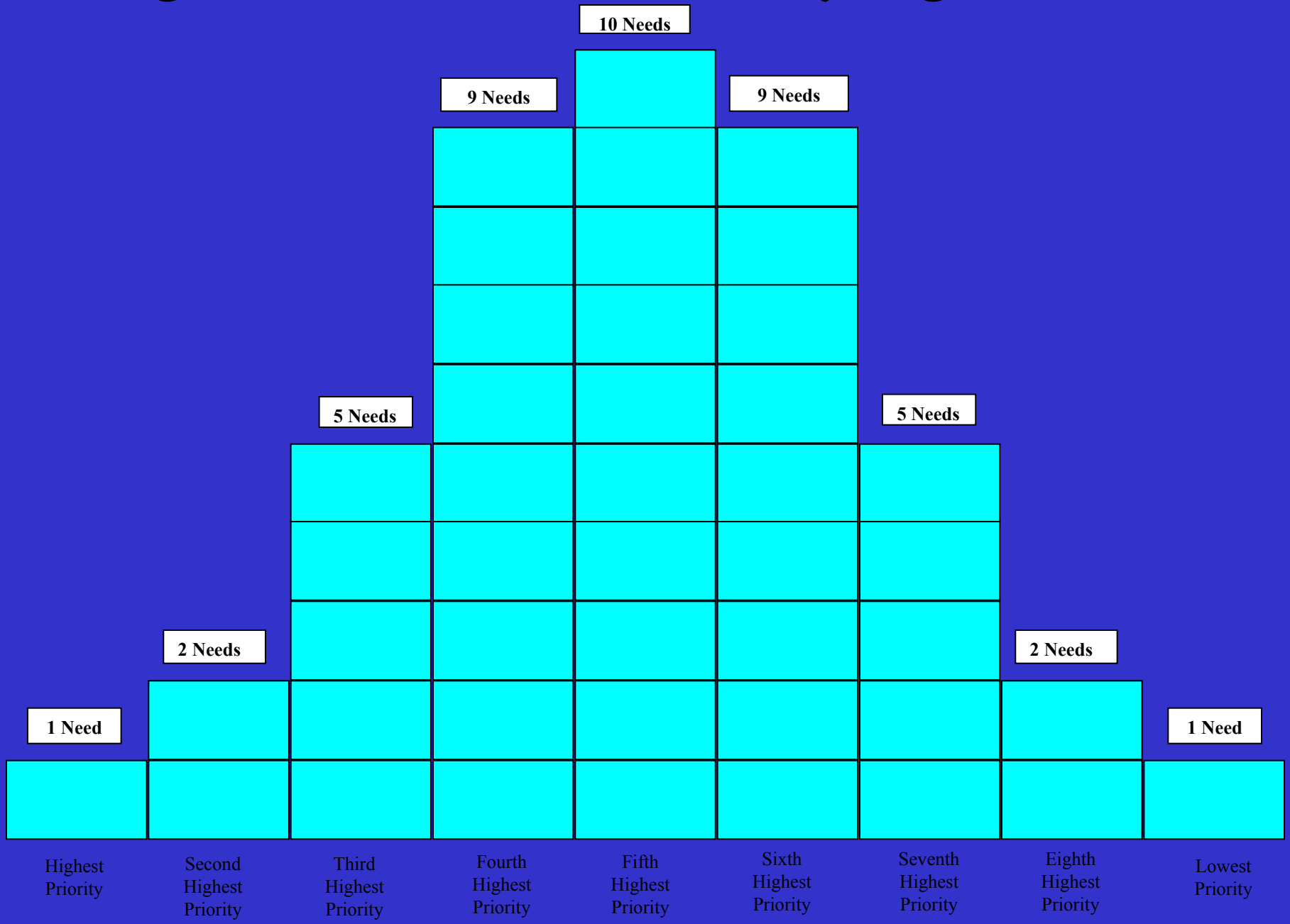
- Purpose: To identify priorities among competing needs
- Stakeholders have unique expertise, perspectives and passions about needs
- All needs cannot be the “highest priority” for the state MCH program
- Q Sort Technique is effective at getting information from people with different backgrounds

What should the table look like?

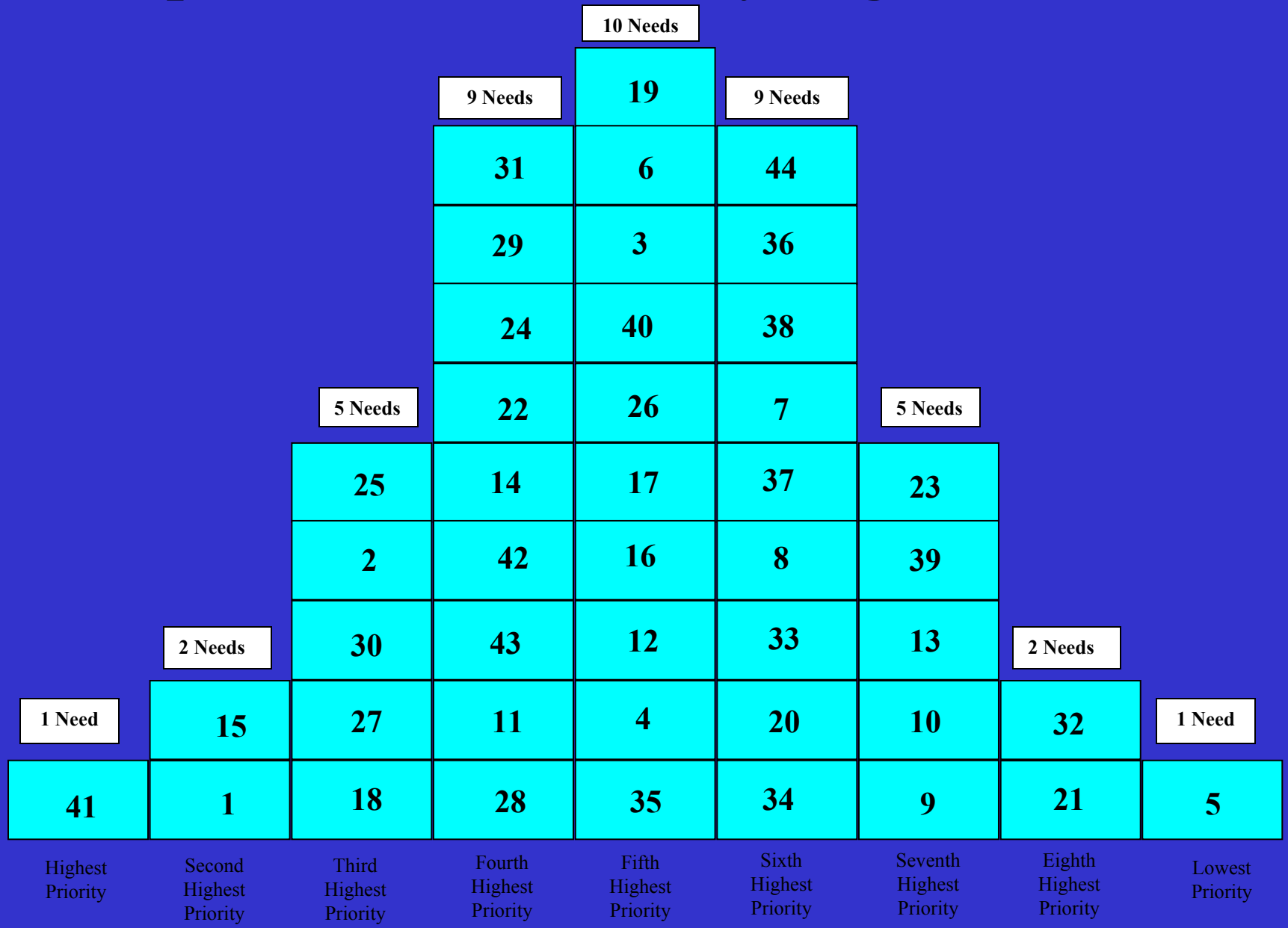
- Create Nine Columns



Inserting Needs on the Q-Sort Priority Log



Completed Q-Sort Priority Log



Data Analysis

- Look at the mean score of each need after gathering responses.
- Scores will be assessed for their variability by using the standard deviation.
- Some scores may be weighted if they are from under-represented fields or regions.

Q-Sort Results
and
Descriptive Statistics

Scoring and Standard Deviation

- *Health Insurance Coverage for Children* has a mean score of 3.28 and had a very small (1.7) standard deviation, you know that most everyone agreed this was a high priority.

Frequency by Geography

Geography	Frequency	Percent
Northern	8	13.1
Northeastern	2	3.3
Southern	7	11.5
Southeastern	11	18.0
Statewide	26	42.6
Western	7	11.5
TOTAL	**61**	**100.0**

Frequency by Agency

- Birth to 3 (1)
- Central Office (16)
- Clinic (1)
- CSHCN Regional Center (7)
- DPI (2)
- Hospital (3)
- LHD (8)
- Managed Health Services (1)
- Private Non Profit (8)
- Regional Office (9)
- University (5)

Frequency by Specialty Area

Specialty	Frequency	Percent
Adolescent	8	13.1
CSHCN	10	16.4
MCH	30	49.3
Other	7	11.5
Preg & Infants	4	6.6
Unknown	2	3.3
TOTAL	**61**	**100.0**

Q-Sort Rank by Population Group

- Women and Infants (14 problems/needs)
- Children and Adolescents (14 problems/needs)
- CSHCN (9 problems/needs

- Note the overlap between the groups
  - color coded

Reach Consensus and Set Priorities

- Size of problem
- Seriousness of problem
- Potential for prevention

Size of the Problem

- Mortality
  - Number
  - Rate
  - High-risk sub-populations: age, gender, race, geography, income, co-morbidity, setting

Size of Problem, cont..

- Prevalence- number of cases in a given populations at a specific time
  - Lifetime
  - Current (point)
- Incidence- the rate of occurrence of new cases in a populations over a period of time

Size of Problem, cont..

- Comparison to Healthy People 2010 and Healthiest Wisconsin 210 goals
- Comparison to U.S. and to other states
- Trends over time

Seriousness of the Problem

- National data defining the problem
- If available, data to define the cost of:
  - Death or YPLL (years potential life loss)
  - Hospitalizations/Disability
- Social and economic consequences

Potential for Public Health Prevention

- Is the problem or need prevented or changed by known interventions ?
- What are the health consequences of not addressing the problem or need?
- Is there current demographic disparity for the problem or need?
- Do other providers identify this as problem or need?
- Are the problems precursors to other problems?

Potential for Public Health Prevention, cont..

- Can the problem/need be measured and evaluated?
- Are their reasonable approaches/strategies for addressing the problem?
  - Provide services directly or contract
  - Regulate the activity
  - Educate public and providers
  - Systems development
  - Data system improvements

Priority Setting Worksheet

- Health Problem/Need
- A: Size of Problem (rate 1-5)
- B: Seriousness of the Problem (rate 1-5)
- C: Potential for Prevention (rate 1-5)
- Priority Score (A + 2B) C
- Rank based on priority score

Priority Setting Process by Population Groups

- Read and discuss the 1st assigned data detail sheet
- Individually rate column A, B, and C (1-5)
- Review the individual results
- Facilitator/assistant will determine the frequency or mean score
- Facilitator will ask: Is this score acceptable that everyone can agree to support it?

To Reach Consensus

- Each person will hold up a colored ticket
  - Green: I agree to support it
  - Yellow: I think I can support it but want more discussion
  - Red : I cannot support it
- Individuals present additional opinions and data to help decision making
- Group must reach consensus at the end

EXAMPLE

Person	A-score	B-score	C-score
1	3	5	3
2	3	5	3
3	2	4	4
4	3	1	4

What is Consensus?

- A collective decision arrived at by a group of individuals working together under conditions that permit communication to be sufficiently open--and the group to be sufficiently supportive--for everyone in the group to fell that he/she has had his/her fair change to influence the decision!!

Consensus is a Process

- It is NOT Conformity
- Acceptable enough that everyone can live with it and agree to support it
- Not everyone must be completely satisfied with the outcome
- Total satisfaction is rare

Consensus
How to make it work

- Pooling opinions
- Effective listening
- Discussing ideas and differences
- Not getting all you want
- Agreement to the point you can live with it
- Support of the final decision

Consensus and Conflict

- Not good or bad - only indicates disagreement
- Is normal: the whole group benefits by exchange of opinion
- Group can experience intense disagreement as long as there remains an assumption of cooperation

Consensus
Breaking an Impasse

- Take a break or go on to the next problem
- Review criteria and standards
- Review the data
- Inject humor to break the tension

Next Steps

(to bring a method to the madness)

- Review the ranking for each group
- Identify solutions and strategies to:
  - Determine whether or not we can do anything about the need and what precisely it is we can and wish to do.

Generate possible solutions related to a priority

- Compare the priority to strategies such as
  - Provide service directly
  - Contract with others to provide service
  - Provide education to public and/or providers
  - Systems development
  - Data system improvement

Generate possible solutions related to priority

- Then ask the following questions for each strategy:
  - How effective would this solution be?
    - Low, medium, high
  - How efficient would this solution be?
    - Low, medium, high
  - How acceptable would this solution be?
    - Low, medium, high

Determine Wisconsin's Title V State Performance Measures

- Compile results and internally finalize recommendations for
  - State Performance Measures
  - Program Direction
  - Resource Allocation
- Present findings to Department
- Include final recommendations for annual Title V Block Grant Application

Statewide Needs Assessment Participants

Name	Agency
1. Ahlers, Therese	WI Infant Mental Health Assoc
2. Andersen, Joyce	DHFS/ DPH/ BCHP
3. Baisch, Mary Jo	
4. Bathke, Vonnie	Parent
5. Berth, Christine	Trempealeau Co Health Dept
6. Bier, Dan	Southern Reg CSHCN Ctr
7. Bjorklund, Lauren	Sauk County Public Health
8. Bradley, Mary	Madison Dept of Public Health
9. Christensen, Linda	Great Lakes Inter-Tribal Cncl
10. Conway, Ann	WI Assoc for Perinatal Care
11. Cook, Wynne	Western Reg CSHCN Ctr
12. Crist, Marie	March of Dimes
13. Cronk, Chris	Medical College of Wisconsin
14. Duquette, Daniel	UW LaCrosse
15. Edwards, Michelle	Price County Health Dept
16. Eide, Yvonne	Southern DPH Reg Office
17. Feller, Carolyn	Brain Injury Association of WI
18. FitzGerald, Charlanne	UW Medical School - Public Health Policy Inst
19. Fleischfresser, Sharon	DHFS/ DPH/ BCHP
20. Gennerman, Mandy	WI Coalition Against Domestic Violence
21. Giese, Lieske	Western DPH Reg Office
22. Gilmore, Claude	DHFS/ DPH/ BCHP
23. Glysch, Randy	DHFS/ DPH/ BCHP
24. Gothard, Mary	DHFS/ DPH/ BCHP
25. Grunewald, Vicki	Midelfort Clinic Pediatrics
26. Hale, Linda	DHFS/ DPH/ BCHP
27. Harris, Robert	Southeastern DPH Reg Office
28. Harvey, Susan	DHFS/ DPH/ BCHP
29. Harvieux, Ann	SUIDs
30. Helm-Quest, Peggy	DHFS/ DPH/ BCHP
31. Henry, Sonja	DHFS/ DPH/ BCHP
32. Hisgen, Jon	Department of Public Instruction
33. Hohlstein, Rita	U.W. Madison
34. Hohlstein, Rita	Waisman Center
35. Holman, Brad	Southeastern Reg CSHCN Ctr
36. Ilgen, Jane	WI Child Care Improvement Prj
37. Katcher, Lilah	DHFS/ DPH/ BCHP
38. Katcher, Murray	DHFS/ DPH/ BCHP
39. Katz, Barbara	ABC for Health Inc
40. Kratz, Susan	DHFS/ DPH/ BCHP
41. Kronser, Ann	Health Care Education/ Training
42. Kruse, Terry	DHFS/ DPH/ BCHP
43. Kvale, Kate	DHFS/ DPH/ BCHP
44. Lathen, Lorraine	Planned Parenthood of WI
45. Lawrence, Jim	Northern DPH Reg Office
46. Leibenthal, Diane	Sheboygan Co HHS

47. Lickteig, Paula.....Northern DPH Reg Office
48. Lindauer, Gary.....DHFS/ DPH/ BCHP
49. Lucinski, Loraine.....DHFS/ DPH/ BCHP
50. Lutz, Lori.....Milw Health Dept Child Care
51. Marcus, Mary .....UW Pediatric Pulmonary Center
52. Mathea, Robin .....Northern Reg CSHCN Ctr
53. McCredie, Jayne.....DHFS/ DPH/ BCHP
54. Medved, Staci.....La Causa Inc
55. Melzer Lange, Marlene .....Children's Hospital of WI - EMSC
56. Miller, Annie .....DHFS/ DPH/ BCHP
57. Miner-Nordstom, Dan .....UW Madison
58. Morgan, Rachel .....Black Health Coalition
59. Muhlenbeck, Beverly .....Sauk Co Public Health Dept
60. Muntner, Kathy .....Oneida Co Health
61. Musial, Cindy .....Southeastern DPH Reg Office
62. Nagel, Muriel.....Madison Dept of Public Health
63. Ngui, Emmanuel.....Medical College of Wisconsin
64. Nothnagel, Jean .....DHFS/ DDES/ Birth to 3
65. Oftedahl, Liz.....DHFS/ DPH/ BCHP
66. Onheiber, Patrice.....DHFS/ DPH/ BCHP
67. Ordinans, Karen.....Children's Health Alliance of WI
68. Paradowski, Jill .....City of Milw Health Dept
69. Pasha, Deb.....Southeastern DPH Reg Office
70. Pauli, Richard .....Clinical Genetics
71. Petersen, Linda .....Western DPH Reg Office
72. Poehlman, Sandy .....Southeastern DPH Reg Office
73. Preston, Kim.....Parent
74. Rahl, Kitty .....Eau Claire City/Co Health Dept
75. Ramspacher, Susan.....WI Coalition Against Domestic Violence
76. Revington, Pence.....Family Living Programs
77. Roach, Kathleen .....Great Lakes Hemophilia
78. Schnoll, Debbie .....Planned Parenthood of WI
79. Schuler, Tom .....DHFS/ DPH/ BCHP
80. Seeliger, Elizabeth.....DHFS/ DPH/ BCHP
81. Siemers, Sheri.....Southern DPH Reg Office
82. Simani, Julie .....WI Women's Health
83. Sondel, Sherie.....Southern DPH Reg Office
84. Spaans Esten, Linda .....DHFS/ DPH/ BCHP
85. Steimle, Meg .....Children's Hospital of WI
86. Stueck, Ann .....DHFS/ DPH/ BCHP
87. Tetzloff, Faye .....Portage Co Health Dept
88. Theurer, Joan.....Northern DPH Reg Office
89. Tunis, Sandra.....Managed Health Services
90. Umentum, Kate .....St Vincents Hospital
91. Uttech, Susan.....DHFS/ DPH/ BCHP
92. Vaughan, Heather.....Great Lakes Inter-Tribal Cncl
93. Vaughn, Mike.....DHFS/ DPH/ BCHP
94. Wartgow, Lynn.....Family Resource Connection
95. Weaver, Brian.....Department of Public Instruction
96. Winecke, Ann-Marie.....DHFS/ DPH/ BCHP

Attachment C – Year 2005 Template Objectives for Maternal and Child Health Program

LEGEND:
- **A Objective Statement**
- **B Deliverable**
- **C Required Context**
- **D Data Source for Measurement**
- **E For Your Information**

MCH/Pregnant Women, Mothers and Infants

A. By December 31, 2005, **xx** pregnant women will receive perinatal care coordination services from **(insert name)** Health Department.

B. A report to document the number of pregnant women who received perinatal care coordination services from **(insert name)** Health Department.

C. Perinatal care coordination services are similar to those provided in the Medicaid Prenatal Care Coordination (PNCC) Program and can be initiated any time during the pregnancy and continue through 60 days after birth. Perinatal care coordination services are targeted to women who are not eligible for Medicaid, or to Medicaid-eligible women who would not have qualified for PNCC because they did not score the minimum 40 points on the Pregnancy Questionnaire.

D. SPHERE Individual/Household Report to include the MCH Required Demographic Data and data from the following screens: Prenatal Assessment; Postpartum Assessment (as appropriate); and Referral and Follow-Up/Results.

MCH/Pregnant Women, Mothers and Infants

A. By December 31, 2005, **xx (choose: % of the - or - insert #)** pregnant women receiving perinatal care coordination services from **(insert name)** Health Department will deliver infants who weigh at least 5.5 pounds.

B. A report to document the **(choose:** number of pregnant women receiving perinatal care coordination services from **(insert name)** Health Department who delivered infants who weighed at least 5.5 pounds - **or -** number of pregnant women receiving perinatal care coordination services from **(insert name)** Health Department, and the number of those women who delivered infants who weighed at least 5.5 pounds.**)**

C. Perinatal care coordination services are similar to those provided in the Medicaid Prenatal Care Coordination (PNCC) Program and can be initiated any time during the pregnancy and continue through 60 days after birth. Perinatal care coordination services are targeted to women who are not eligible for Medicaid, or to Medicaid-eligible women who would not have qualified for PNCC because they did not score the minimum 40 points on the Pregnancy Questionnaire. It is more likely that infants will be delivered who weigh at least 5.5 pounds if perinatal care coordination services are provided to pregnant women during the first and second trimester, as opposed to women who initiate these services after the second trimester.

D. SPHERE Individual/Household Report to include the MCH Required Demographic Data and data from the following screens: Prenatal Assessment; Postpartum Assessment; and Referral and Follow-Up/Results.

LEGEND:
- **A Objective Statement**
- **B Deliverable**
- **C Required Context**
- **D Data Source for Measurement**
- **E For Your Information**

MCH/ Children, Adolescents and their Families

A. By December 31, 2005, **xx** children ages birth through **xx** years who are not Medicaid eligible will receive a comprehensive primary health exam, necessary referral and follow-up services from **(insert name)** Health Department.

B. A report to document the number of children ages birth through **xx** years who are not Medicaid eligible and received a comprehensive primary health exam, necessary referral and follow-up services from **(insert name)** Health Department.

C. Comprehensive primary care for children includes a well-child examination and the necessary primary health care services, education and anticipatory guidance to maintain optimal health status, and is reflected in "Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents."

D. SPHERE Individual/Household Report to include the MCH Required Demographic Data and data from the following screens: Physical Assessment; Infant Assessment (birth-12 months); Developmental Assessment; Health Care Utilization; Height/Weight; Head Circumference; Hemoglobin/Hematocrit; Lead; Referral and Follow-Up/Results if need is identified; and Health Teaching and Results.

MCH/ Children, Adolescents and their Families

A. By December 31, 2005, **xx** children ages birth through **xx** years from **(insert name of jurisdiction)** will be properly positioned in a child car passenger seat system as demonstrated by their parent or caregiver.

B. A report to document the number of children ages birth through **xx** years from **(insert name of jurisdiction)** who were properly positioned in a child car passenger seat system by their parents or other caregivers.

C. This objective is for local health department programs that provide designated individual assessment, installation and instruction services to families with one or more children in the selected age group.

D. SPHERE Individual/Household Report to include MCH Required Demographic Data and data from the following screens: Child Passenger Seat Safety Assessment.

E. Selection of this objective corresponds to its designation for **Applicable Objective Type** of "Individual or Family" on the **Objective: Other Details** screen of GAC system. Child passenger seat programs are expected to follow the recommendations of the National Highway Traffic Safety Administration www.nhtsa.dot.gov and to employ certified staff in their programs. If using the SafeKids form, you must also collect and report additional MCH Program required data: the birth date and race of the child and health care coverage information.

LEGEND: **A Objective Statement**
B Deliverable
C Required Context
D Data Source for Measurement
E For Your Information

MCH/Children, Adolescents and their Families

A. By December 31, 2005, **xx** residences located within **(insert name of jurisdiction)** with children ages **xx** to **yy** years will have a documented decrease in hazards previously identified through home safety assessments.

B. A report to document, by residence (household), the corrections made for hazards identified through home safety assessments.

C. **(Specify the staff who will provide the home safety assessment; for example, Public Health Nurse, Public Health Educator, or trained volunteer. List the name or type of the standardized tool that will be used for the home safety assessment. Indicate the method of assuring correction of hazards identified; such as, written improvement plan, installation of safety devices, referral to community partners, letters written to landlords.)**

D. SPHERE Individual/Household Report to include MCH Required Demographic Data and data from the following screens: Injury Prevention Assessment OR Home Safety Assessment of Young Children; Health Teaching Topics and Results; and Referral and Follow-Up/Results if appropriate.

E. Selection of this objective corresponds to its designation for **Applicable Objective Type** of "Individual or Family" on the **Objective: Other Details** screen of the GAC system. A draft copy of the "Check List for Home Safety Assessment of Young Children" is available from Division of Public Health, Bureau of Community Health Promotion.

MCH/Children, Adolescents and their Families

A. By December 31, 2005, **xx** children ages 6 months to 5 years will receive early childhood caries prevention services from the **(insert name)** Health Department.

B. A report to document, by child's age and type of service, the early childhood caries prevention services provided by **(insert name)** Health Department.

C. The following maternal and early childhood oral health preventive services are integrated into primary health care visits; anticipatory guidance for parents and other caregivers, an oral assessment for infants and children ages 6 months through 5 years, fluoride varnish applications (up to 3 applications per year per child) and referral to a dentist if necessary. **(List expected sites to outreach for services to infants and young children; such as, health clinics, WIC Program, Head Start or Early Head Start, child care programs.)**

D. SPHERE Individual/Household Report to include the MCH Required Demographic Data and data from the following screens: Oral Health Assessment; Fluoride Assessment; and Referral and Follow-Up/Results.

E. A physician, dentist or advanced practice nurse must prescribe fluoride varnish. Staff training, technical assistance and materials are available through the Department of Health and Family Services Oral Health Program.

LEGEND: **A Objective Statement**
B Deliverable
C Required Context
D Data Source for Measurement
E For Your Information

MCH/Children, Adolescents and their Families

A. By December 31, 2005, **xx** third grade students who are uninsured or under-insured will receive an oral health assessment from **(insert name)** Health Department.

B. A report to document the number of third grade students who are uninsured or under-insured and received an oral health assessment from **(insert name)** Health Department.

C. (Estimate the number or percent of third grade children in your jurisdiction who are eligible for free or reduced lunch or who are uninsured or under-insured; e.g., undocumented clients, and indicate if this objective will attempt to focus on the schools in your jurisdiction that have the highest rates of these children).

D. SPHERE Individual/Household Report to include the MCH Required Demographic Data and data from the following screens: Oral Health Assessment and Referral and Follow-Up/Results.

E. In 2001-2002, a statewide representative random sample of third grade children ("Make Your Smile Count Survey") was conducted by the Department of Health and Family Services (DHFS). This survey report provides a statewide and regional analysis of the oral health status of third grade children; including, untreated dental caries, caries experience, dental sealant prevalence and treatment urgency. County surveys may be compared with state and regional data as a part of an oral health needs assessment. Staff training, technical assistance and material are available through the Department of Health and Family Services' Oral Health Program.

MCH/Children, Adolescents and their Families

A. By December 31, 2005, **xx** children who have their first and second permanent molars and are not Medicaid eligible will receive oral health assessment, dental sealants and necessary referral to a dentist from **(insert name)** Health Department.

B. A report to document the number of those children who have their first and second permanent molars, are not Medicaid eligible, and received oral health assessment dental sealants and necessary referral to a dentist from **(insert name)** Health Department.

C. School-based dental sealant programs are evidence-based prevention strategies that prevent dental caries (cavities) in the pits and fissures of permanent molars. The children targeted by this objective are usually second and sixth or seventh graders. **(Estimate the number or percent of second and sixth or seventh grade children in your jurisdiction who are not Medicaid eligible.)**

D. SPHERE Individual/Household Report to include the MCH Required Demographic Data and data from the following screens: Oral Health Assessment and Referral and Follow-Up/Results.

E. A dentist must screen and prescribe dental sealants. A dental hygienist may place dental sealants without a dentist present with a prescription from a dentist. Technical assistance is available through the Department of Health and Family Services' Oral Health Program.

MCH/Children, Adolescents and their Families

A. By December 31, 2005, xx newborns and their parent(s) will receive one home visit by a Public Health Nurse with necessary referral and follow-up services from (insert name) Health Department.

B. A report to document the number of newborns and their parents who received at least one Public Health Nurse home visit and necessary referral and follow-up services from (insert name) Health Department.

C. The home visit services, which might include health education, anticipatory guidance to maintain optimal health status, referral and follow-up services, are reflected in "Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents." **(Specify if the home visits will target a specific high-risk group.)**

D. SPHERE Individual/Household Report to include the MCH Required Demographic Data and data from the following screens: Postpartum Assessment (excluding add birth record); Infant Assessment (birth-12 months); Health Teaching Topics; and Referral and Follow-Up/Results if need is identified.

MCH/All Populations

A. By December 31, 2005, **xx (insert population focus)** who participate in (**insert type of health education activity)** sponsored by **(insert name)** Health Department will demonstrate an increase in knowledge related to **(insert topic)**.

B. A report to document the number of **(insert population focus)** who participated in (**insert type of health education activity)** sponsored by **(insert name)** Health Department and demonstrated an increase in knowledge related to **(insert topic);** and a copy of the tool used to measure the change in knowledge.

C. This objective is intended for group activities. **(Insert a brief discussion of the topic areas and population groups that you are considering to impact with this objective.)**

D. SPHERE Community Report to include the data from the following screens: Community Activity (all appropriate fields) and Health Teaching Topics and Results.

E. Topics may include, but are not limited to, those on the SPHERE Intervention Health Teaching list. Examples of MCH priority topics include, but are not limited to, Access to Care; Adolescent Health/Abstinence/High Risk Sexual Behavior/Pregnancy Prevention; ATODA; Breastfeeding Support; Child Care/Day Care; Domestic Violence; all Injury Prevention topics including Child Passenger Safety, Bike Safety, Gun Safety and Home Safety; Bullying Prevention; CSHCN

Services; Depression; Oral Health; Parenting; Pregnancy Education; Perinatal Depression; Physical Activity/Active Lifestyle (including Bike/Walk to School USA activities); Racial Disparities; Suicide Prevention and Tobacco Prevention. Agencies conducting Bike/Walk to School USA activities should register on www.walktoschool-usa.org and communicate with the DPH Physical Activity Coordinator, Jon Morgan at morgajg@dhfs.state.wi.us.

MCH/All Populations

A. By December 31, 2005, **xx (insert population focus)** from **(insert name)** County enrolled in **(insert name of health activity)** will demonstrate or self-report **(choose: an increase - or - a decrease)** in **(insert specific health-related behavior, practice or skill)**.

B. A report to document the number of **(insert population focus)** from **(insert name)** County enrolled in **(insert name of health activity)** who demonstrated or self-reported **(choose: an increase - or - a decrease)** in **(insert specific health-related behavior, practice or skill);** and a copy of the tool used to measure the change in knowledge.

C. This objective is intended for group activities. **(Insert a brief discussion of the health activity areas and population groups that you are considering to impact with this objective.)**

D. SPHERE Community Report to include the data from the following screens: Community Activity (all appropriate fields) and Health Teaching Topics and Results.

E. Topics may include, but are not limited to those from the SPHERE Intervention Health Teaching list. Examples of MCH priority topics include, but are not limited to Access to Care; Adolescent Health/Abstinence/High Risk Sexual Behavior/Pregnancy Prevention; ATODA; Breastfeeding Support; Child Care/Day Care; Domestic Violence; all Injury Prevention topics including Child Passenger Safety, Bike Safety, Gun Safety and Home Safety; Bullying Prevention; CSHCN Services; Depression; Oral Health; Parenting; Pregnancy Education; Perinatal Depression; Physical Activity/Active Lifestyle (including Bike/Walk to School USA activities); Racial Disparities; Suicide Prevention and Tobacco Prevention. Agencies conducting Bike/Walk to School USA activities should register on www.walktoschool-usa.org and communicate with the DPH Physical Activity Coordinator, Jon Morgan at morgajg@dhfs.state.wi.us

MCH/Nutrition Focused Coalition Plan

A. By December 31, 2005, **xx** strategies for improving the nutrition and health of families residing in **(insert name of jurisdiction)** will be implemented by the **[(insert name) and choose: County Nutrition and Physical Activity or Hunger Prevention Coalition or Food Safety and Preparedness]** Coalition.

B. A report to document the coalition and the number of strategies it implemented for improving the nutrition and health of families residing in **(insert name of jurisdiction)**.

LEGEND: **A Objective Statement**
B Deliverable
C Required Context
D Data Source for Measurement
E For Your Information

C. This objective is for systems activities with a focus on community nutrition. A coalition will be defined as being at least four member organizations. Implementing strategies is based upon the completion of a nutrition needs assessment and development of a community nutrition plan. Working with others in groups, such as in coalitions, is a powerful and effective way to address challenging issues and bring about community change. Infrastructure should include nutrition expertise and physical activity expertise, as appropriate.

D. SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the strategies documented in the Results/Outcome field) and Intervention: Coalition Building.

E. A useful resource for developing and implementing effective coalitions is "A Manual for Building for Local Leadership for Community Nutrition Health" (distributed to all WIC Projects).

MCH/Breastfeeding Duration

A. By December 31, 2005, **xx** women who received prenatal case management services from the **(insert name of jurisdiction)** Health Department will initiate and continue to breastfeed for at least one month.

B. A report to document the number of women who had received prenatal case management services from the **(insert name of jurisdiction)** Health Department, initiated and then continued to breastfeed for at least one month.

C. The goal is for local prenatal case management services, including perinatal care coordination or Medicaid Prenatal Care Coordination, to promote initiation of breastfeeding immediately upon delivery and to support sustained breastfeeding. The target group is women who give birth during the period December 2004 through November 2005.

D. SPHERE Individual/Household Report to include MCH Required Demographic Data and data from the following screens: Prenatal Assessment, Postpartum Assessment, Referral and Follow-up/Results.

Organizational Structure
Department of Health and Family Services
Division of Public Health

May 2005

Fiscal / Budget Mgmt
Grants Monitoring
Contract Monitoring
Public Health Info
Webpage
Education / Training
Communications
Distance Learning
IT Network Security

Personnel, Mail, Fleet
Printing, Forms, Records
Purchasing, Invoicing
Space
Telecommunications
IT Liaison
Performance Based Contracts
Division Receptionist
Desktop Support

Division Administrator
Vacant
Indef. Agency Appt 90-05

Executive Staff Assistant
Vacant
81-04

Office of Operations
Sherry Gehl
Public Hlth Ops Office Dir
81-02

Deputy Administrator
Herb Bostrom
81-01

Executive Staff Assistant
Deb Ehle
81-04

Communicable Diseases & Preparedness
Akan Ukoennin
Public Hlth Mgr 81-01

Public Health and Hospital Preparedness

Chief Medical Officer & State Epidemilogist
Communicable Diseases & Preparedness

Communicable Disease / Epidemiology
Physician Supv 50-51

International Health
TB Elimination
Anti-TB Medication Program
Infection Control Consultation
Hepatitis A
Food / Waterborne Outbreaks
Disease Surveillance / Epidemiology
Public Health Veterinarian
Influenza Surveillance
Vectorborne Surveillance
Outbreak Investigation
State Laboratory of Hygiene Liaison
Emerging Pathogens Consultation

Immunization
HFS Supv 81-03

National Pharma Central Stockpile
WI Immunization Registry
Vaccine for Children
Hepatitis B
Adult Immunization
School Immunization
Vaccine Purchase / Distribution
Vaccine Preventable / Disease Surveillance
Contract Monitoring
Education / Consutlation / Technical Assistance

Sexually Trans Disease
Federal Advisor

Surveillance / Epidemiology
Consultation / Technical Assistance
Prevention
Syphllis Elimination
Partner Notification

AIDS / HIV
Physician Supv 50-51

Ryan White Care Services
Counseling and Testing
Early Inervention
Insurance Continuation
HIV Prevention
Case Management
Partner Counseling & Referral
Drug Reimbursement
Hepatitis C
Surveillance / Epidemiology

Community Health Promotion
Millie Jones
Public Hlth Mgr 81-01

Chief Medical Officer
Maternal & Child Health and Chronic Disease

Chief Dental Officer

Oral Health
Marquette Dental

Family Health
HFS Mgt Supv 81-02

WI Well Woman Program
Preconceptional / Reproductive Hlth
Maternal / Perinatal Health
Infant / Young Child Health
Adolescent Health
Children w/Special Health Care Needs
Youth Policy
Birth Defect Surveillance
Congenital Disorders
Health Education and Systems
Genetics
Universal Newborn Hearing
Organ Donor Program
Injury Prevention
Injury Epi & Consultation
EMS for Children
Sexual Assault Prev
Violent Death Reporting System

Nutrition & Physical Activity
Public Health Nutrition
Section Chief 81-02

Nutrition & Physical Activity
WIC Program
Breastfeeding
MCH Nutrition
CSHCN Nutrition
WIC Farmers Market Nutrition Progam
Milwaukee County WIC Project
WIC Vendor Authorization
Vendor Fraud and Abuse
Participant Fraud & Abuse
Commodity Supplemental Food Program
Food Security

Chronic Disease & Cancer Prevention
HFS Mgt Supv 81-02

Chronic Disease Epi
Diabetes Prevention and Control Program
Cancer Control
Arthritis Control Prog
Cardiovascular Disease Program
Prostate Cancer

Tobacco Prevention Program
HFS Mgt Supv 81-02

CDC Comprehensive Tobacco Prevention and Control
WI WINS
Media Campaign
Cessation
Disparities Initiative

Environmental & Occupational Health
Tom Sieger
Environmental Hlth Mgr 81-01

Env Health Capacity Building

Chief Medical Officer
Environmetal and Occupational Health

Food Safety & Recreational License
Public Hlth San Supv 81-03

Restaurant, Lodging &Recreational
Facility Licensing
Body Art Regulation
Sanitarian Registration
Food Manager Certification

Health Hazard Evaluation
Env Hlth Supv 81-02

Hazardous Waste Site Assess.
Hlth Hazards Invest
Indoor Air Quality
Toxicology
Groundwater Standards
Sport Fish Consumption
Env. and Occupational Epi
Env Health Tracking
Chemical Threat Preparedness
Asthma Intervention
Fatalities Assessment & Control
Evaluation
Antrhax & Occupational Surveillance

Radiation Protection
Nuclear Eng Mgr 81-01

Radiological Emergency Response
Radioactive Materials Program
Radon Prevention
Radiation Monitoring
X-Ray Registration
Mammography Quality Assurance

Asbestos and Lead(Pb)
HFS Supv 81-02

Asbestos Training & Certification
Lead Training & Certification
Lead / Asbestos Outreach & Education
Childhood Lead Poisoning Prevention
Adult Lead Poisoning Prevention
Lead (Pb) Property Registry

Health Information & Policy
Susan Wood
Adminstrative Mgr 81-01

Chief Epidemiologist

State Registar/Vital Records
State Registrar 81-02

Registration and Statistics
Customer Service and Records Search
Special Records / Historical Preservation

Population Health
RA Adv Supv 81-03

Analysis, Reports, and Record Linking using
BHI, DHFS and other data sets
Demographic Information
Web-based Query System and Publications
Family Health Surveys
Behavioral Risk Factor Survey
Statistical and Methodological Consultation

Health Care Information
RA Adv Supv 81-03

Physician Office Visit Data
Workforce Surveys
Health Institution Surveys
Cancer Registry
Board on Health Care Information
Institutional Review Board

Policy
P & PA Adm 81-02

Coordination and Implementation of
State Health Plan
Coordination and Implementation of Integrated
IT Systems
Public Health Information Network (PHIN)
Minority Health Coordinator
Workforce Development
Public Health Nursing
Oral Health Workforce and Policy
Epidemiology
Public Health Restructing Initiative
Public Health Council
Cooperative American Indian Health

Local Health Support & Emergency Medical Svcs
Meg Taylor
Public Hlth Manager 81-01

Guardcare
Prevention Block Grant Health Services
Public Health Statutues
Primary Care
Health Care for the Homeless
HPSA
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Community Health Centers

Regional Offices

Northern Regional Office

Northeastern Regional Office

Southern Regional Office

Southeastern Regional Office

Western Regional Office

Bioterrorism Preparedness
Facility Inspection
Contract Monitoring
Technical Assistance
Liaison to Local Agencies
HFS 140 Local Health Dept. Review

EMS System & Lic
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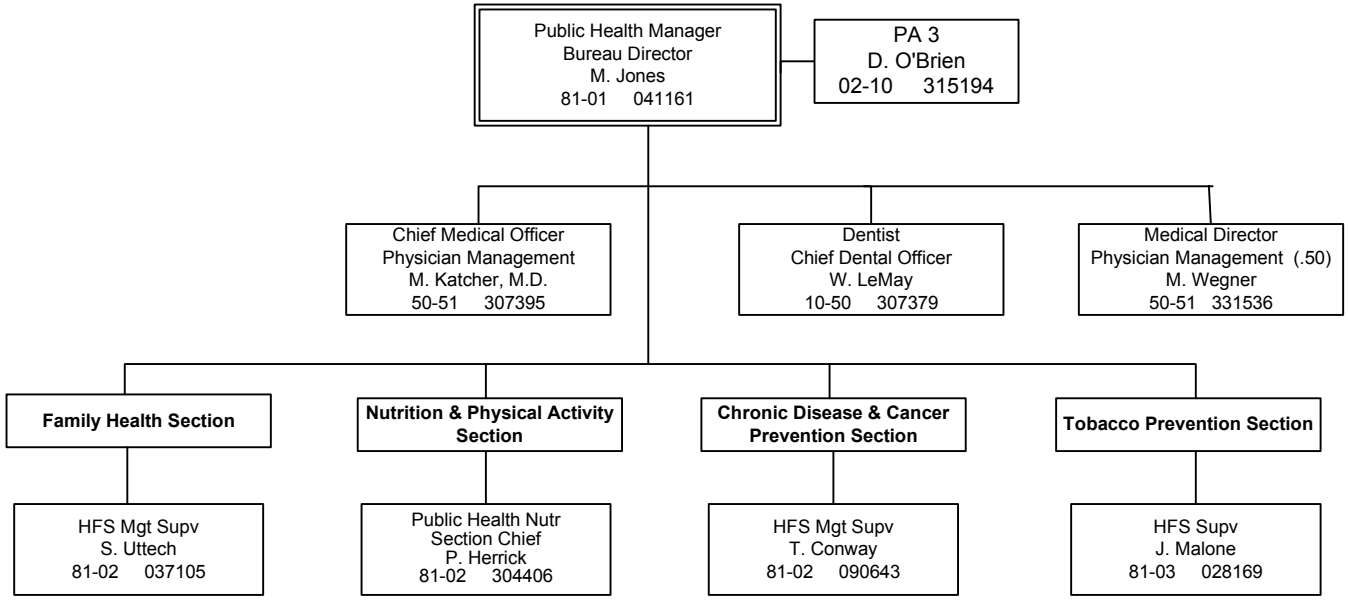
First Responder/Defib Cert
EMT Licensing
Training Approval
Licensing Exams
Ambulance Prov Lic
Paramedic Lic
Surveillance
Data Collection
Quality Assurance
Funding Assist Prog
Comm System
Basic/Adv Life Supp
Trauma
Bioterrorism Preparedness

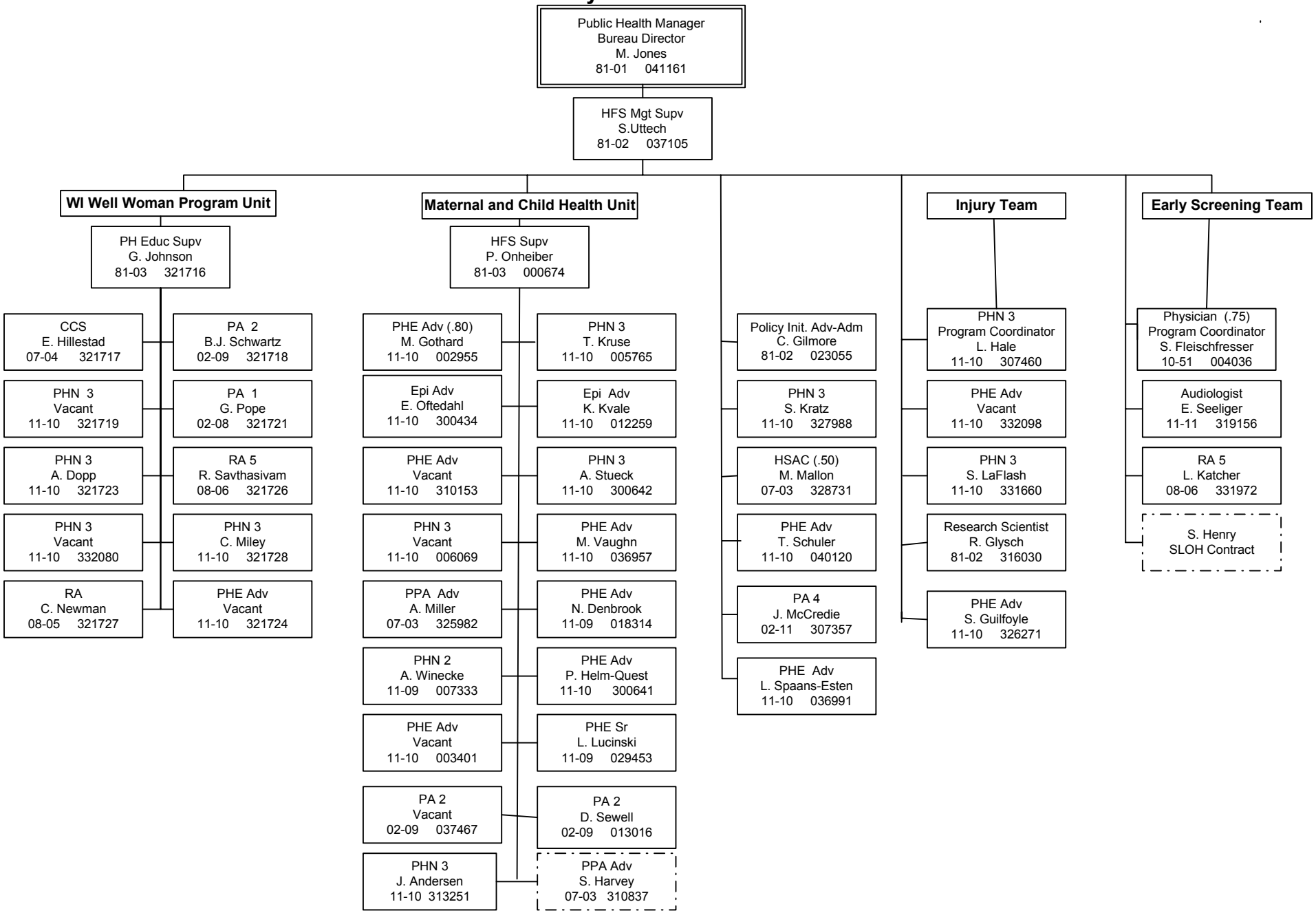
Division of Public Health
Bureau of Community Health Promotion
Bureau Director's Office

May 2005



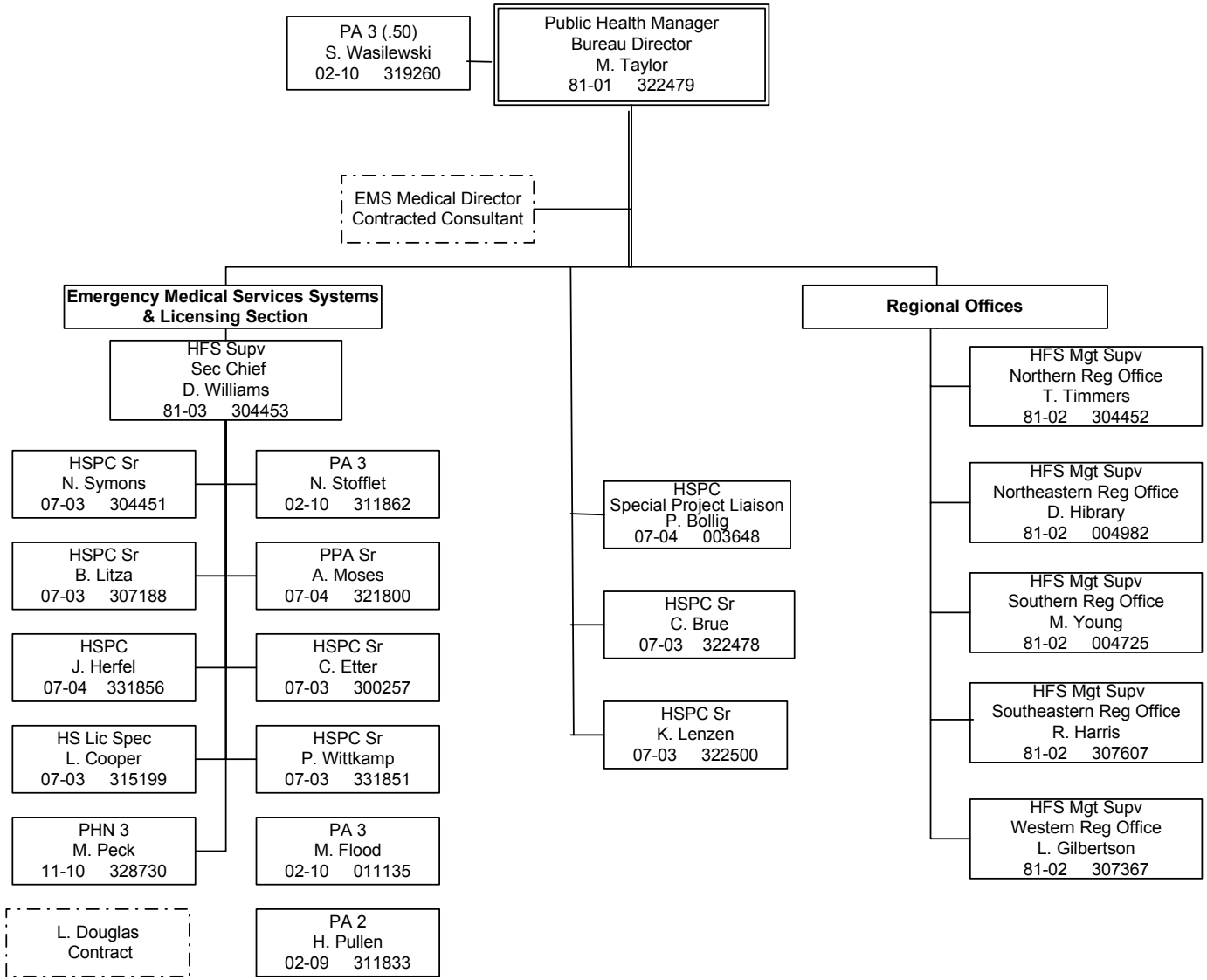
Division of Public Health
Bureau of Community Health Promotion
Family Health Section

May 2005



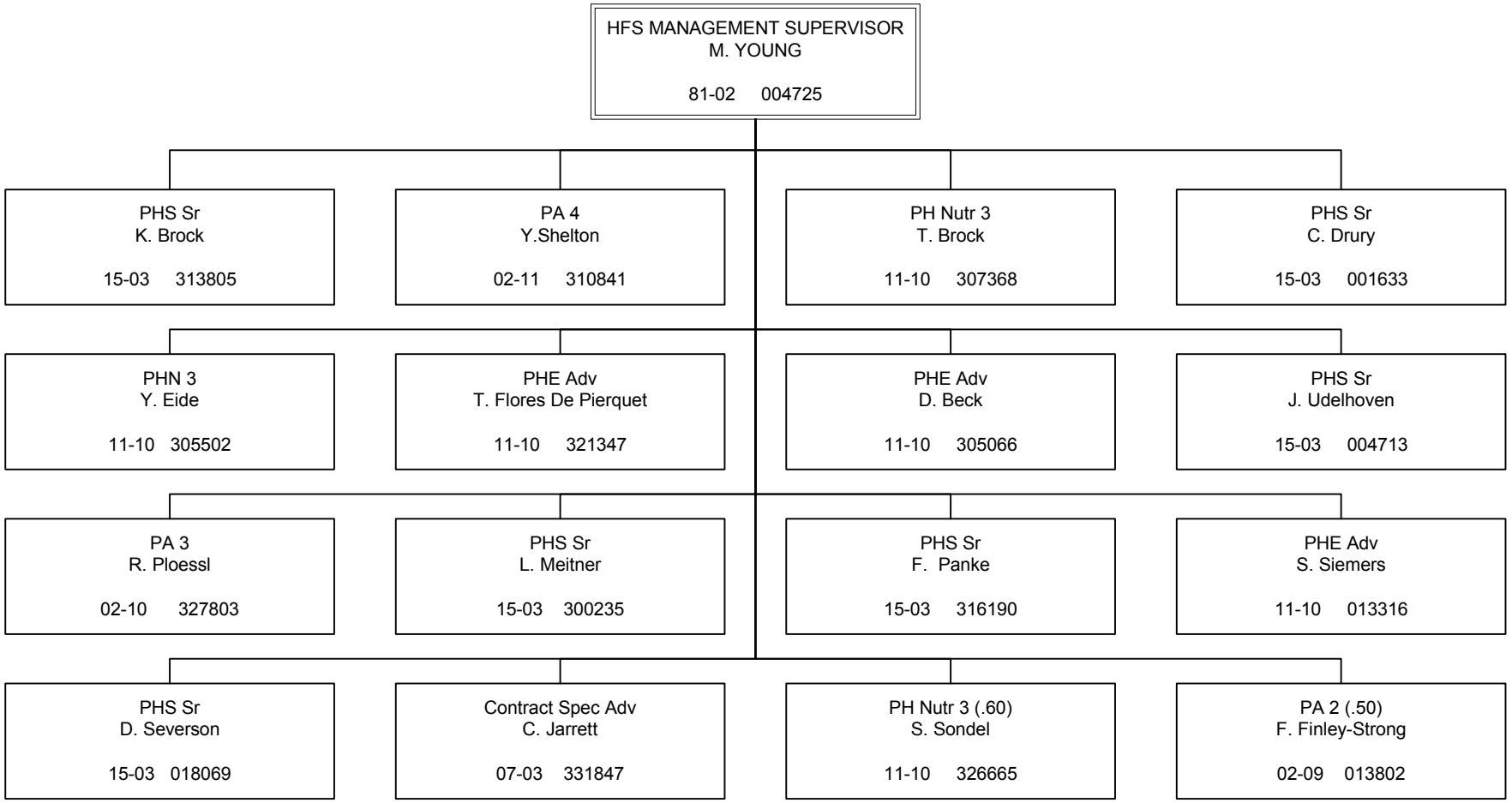
May 2005

Division of Public Health
Bureau of Local Health Support and Emergency Medical Services



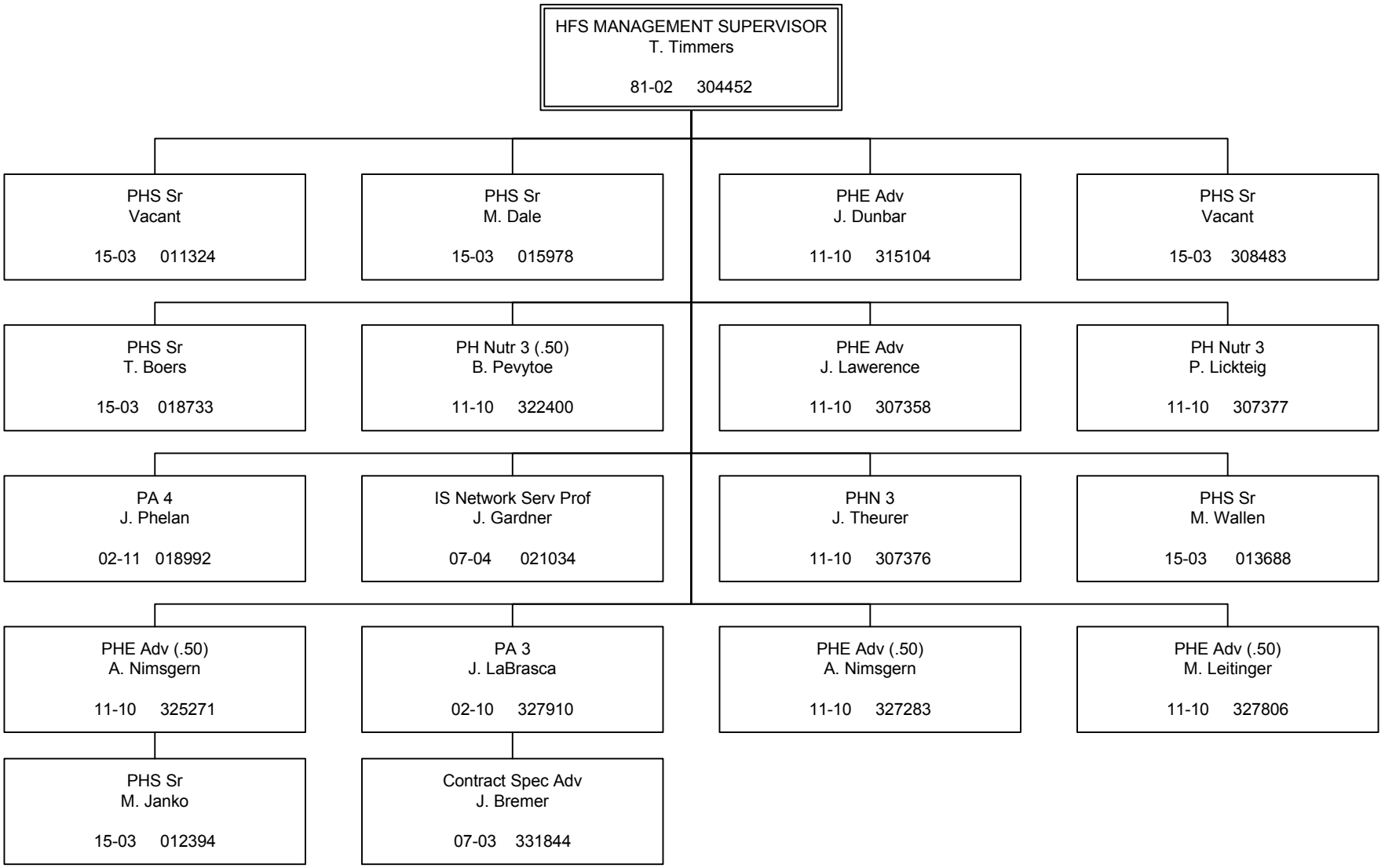
May 2005

Division of Public Health
Madison Regional Office
(Southern)



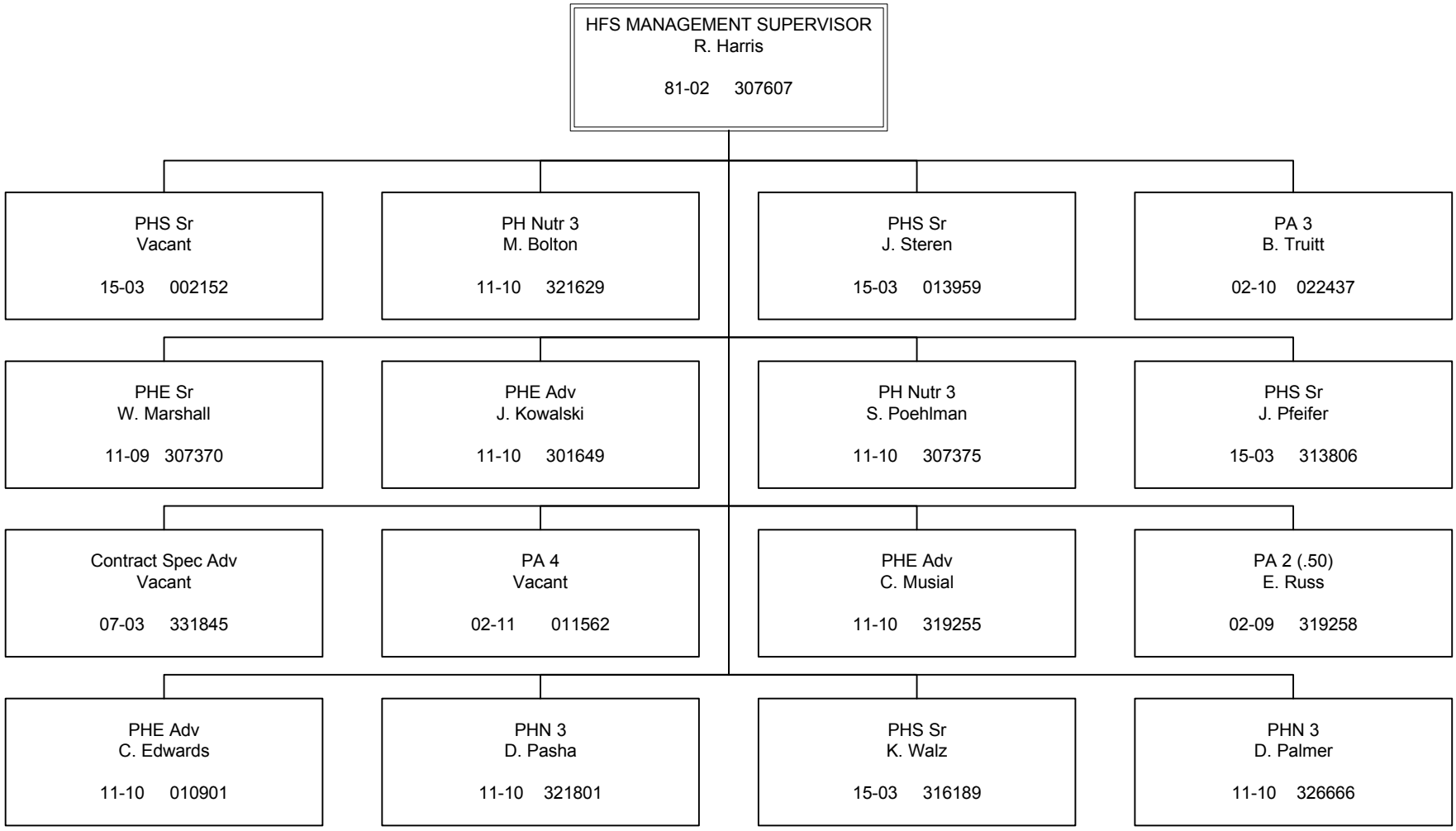
May 2005

Division of Public Health
Rhinelander Regional Office
(Northern)



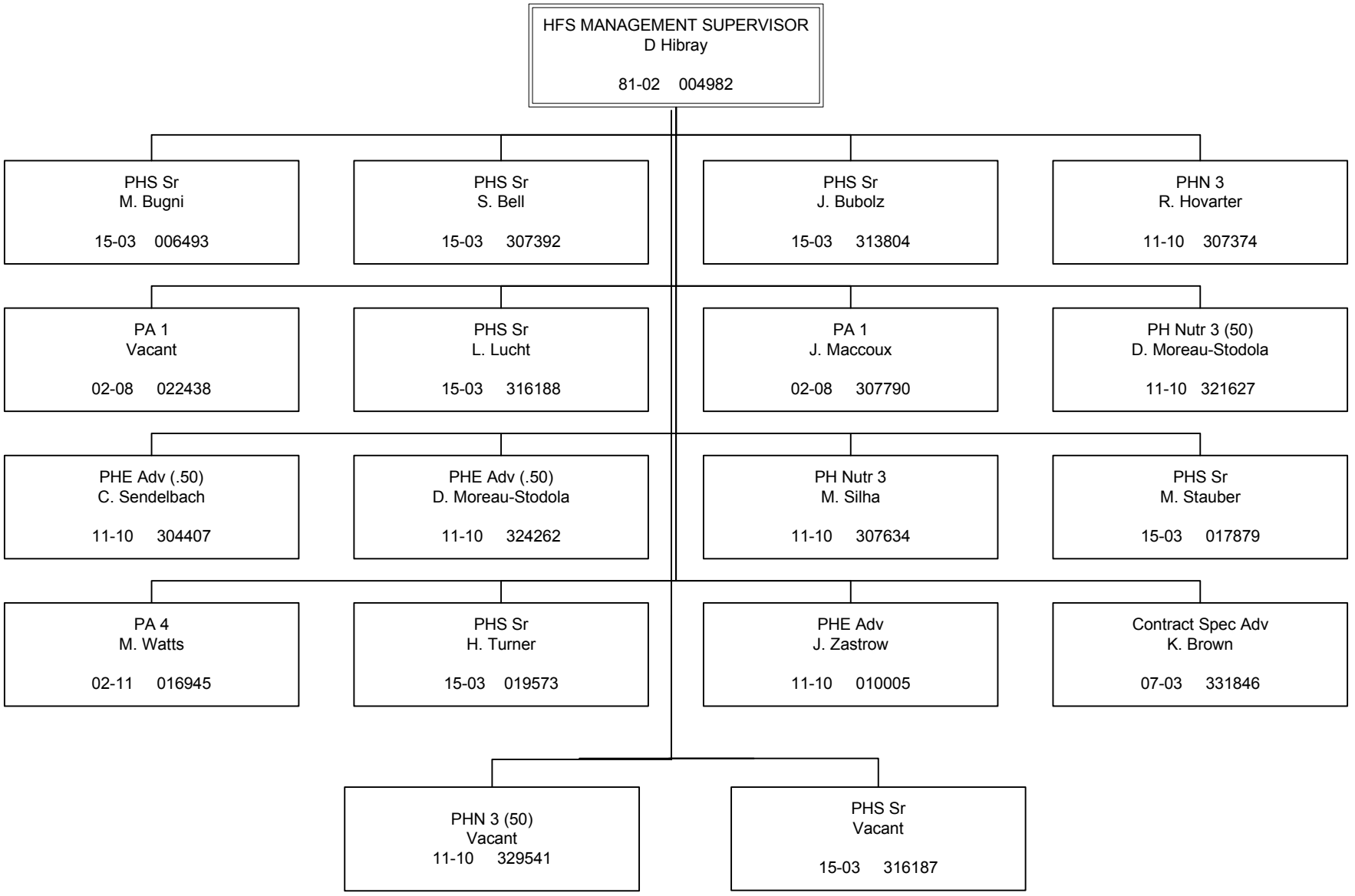
May 2005

Division of Public Health
Milwaukee Regional Office
(Southeastern)



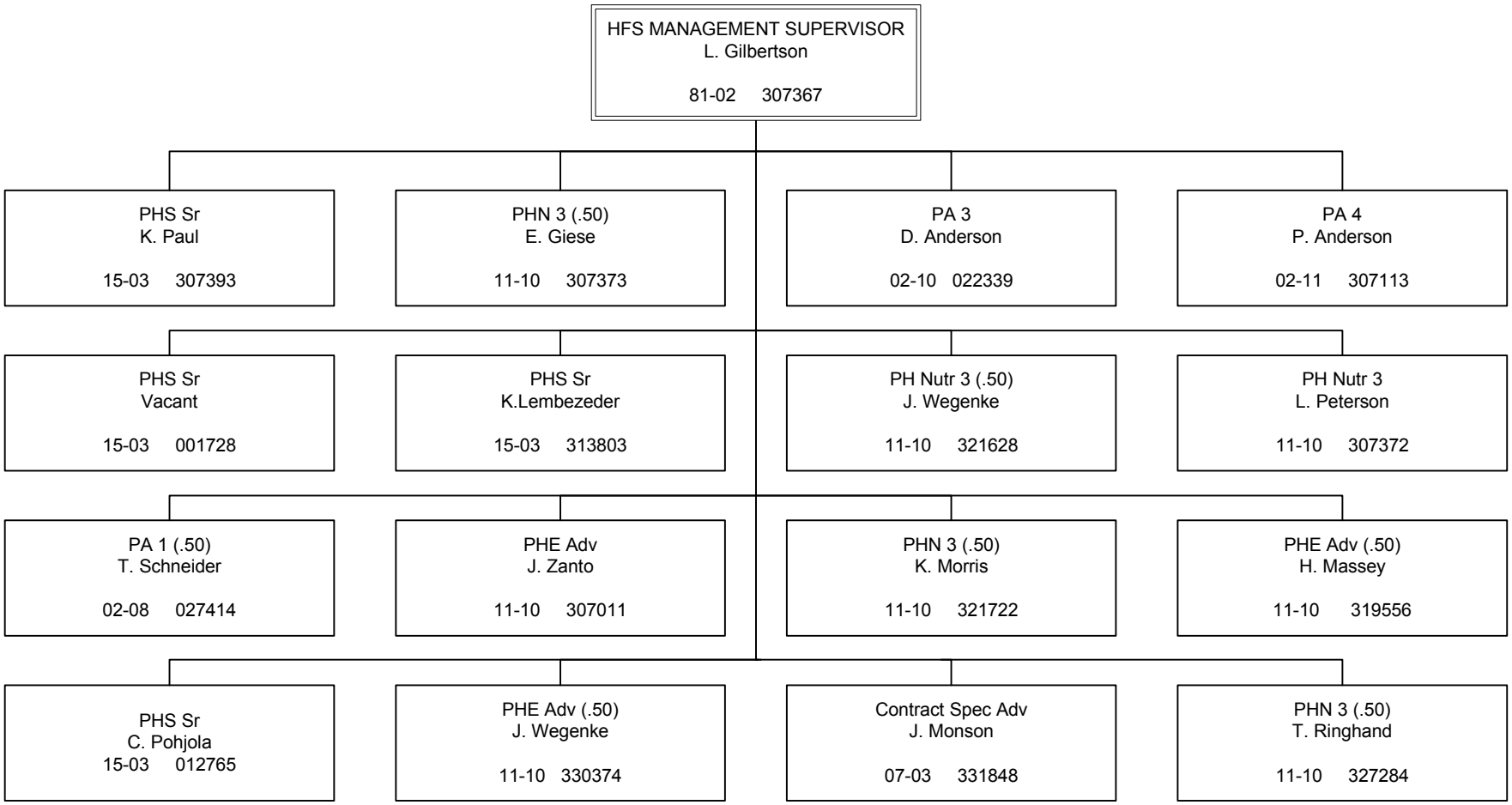
May 2005

Division of Public Health
Green Bay Regional Office
(Northeastern)



May 2005

Division of Public Health
Eau Claire Regional Office
(Western)



WISCONSIN TRIBAL HEALTH CENTERS

Agency Name & Address	Phone No. Fax No.	Agency Contact (E-mail address)
Bad River Tribal Health Clinic P.O. Box 250 303 Elm Street Odanah, WI 54861-0039	715 682-7137 715 685-2601 (Fax)	Mary Bigboy, Health Director Mbigboy@badriver.com
Forest County Potawatomi Health and Wellness Center 5409 Everybodys Road P.O. Box 396 Crandon, WI 54520	715 478-4309 715 478-4499 (Fax)	Linda Helmick, Health Director lindah@fcpotawatomi.com
Ho-Chunk Nation Health Department P.O. Box 636 Black River Falls, WI 54615-0636	715 284-9851 715 284-9592 (Fax)	Hattie Walker, Health Director Hwalker@ho-chunk.com
Lac Courte Oreilles Community Health Center 13380W. Trepania Road Hayward, WI 54843-2186	715 634-4795 715 634-6107 (Fax)	Donald Smith, Health Director Grindcreek@hotmail.com
Menominee Tribal Clinic P.O. Box 970 Keshena, WI 54135-0970	715 799-5482 715 799-3099 (Fax)	Jerry Waukau, Health Director Jerryw@mtclinic.net
Oneida Community Health Center P.O. Box 365 Oneida, WI 54155-0365	920 869-2711 920 869-1780 (Fax)	Deanna Bauman, Health Administrator dbauman@oneidanation.org
Peter Christensen Health Center 450 Old Abe Road Lac du Flambeau, WI 54538	715 588-4272 715 588-9821 (Fax)	Randy Samuelson, Health Director rsamuelson@ldftribe.com
Red Cliff Community Health Center Post Office Box 529 Bayfield, WI 54814-0529	715 779-3707 715 779-3777 (Fax)	Patricia Deragon, Health Director Pderagon@redcliff-nsn.gov
Saint Croix Tribal Health Center 4404 State Road 70 Webster, WI 54893-9251	715 349-8554 715 349-2559 (Fax) 877 455-1901 (toll-free)	John Seppanen, Health Director jssihs@hotmail.com
Sokaogon Chippewa Indian Clinic 3163 State Hwy 55 Crandon, WI 54520	715 478-5180 715 478-5904 (Fax)	Tammy Retzlaff, Health Director Retzlaff04@yahoo.com
Stockbridge-Munsee Health & Wellness Center W12802 Court Rd. A, PO Box 86 Bowler, WI 54416	715 793-5007 715 793-4120 (Fax)	Maurice Ninham, Health Director maurice.ninham@mohican.com
Additional resources may be available via:		
Great Lakes Inter-Tribal Council P.O. Box 9 Lac du Flambeau, WI 54538	715 588-3324 715 588-7900 (Fax)	http://www.glitc.org

If you have updates for this list, please send them to WEBMAILdph@dhfs.state.wi.us *(Last Updated 4/26/2005)*

March 1, 2005

Status: Recommended MCH Statewide Projects

Available Funds and Cycle

- $760,000 are available for a 12-month contract beginning July 1, 2005. However, the initial contract will be in effect for 18 months ending December 31, 2006.
- For the first year, the allocation will be less than in previous years because in 2004 Wisconsin's federal grant award was reduced by nearly $700,000.
- After the first 18-month contract, funds will increase slightly each year through 2008 reaching $922,600 provided Wisconsin's Title V allocation remains level. Plans are to maintain that amount earmarked for statewide projects through 2010 (again, provided that federal funding levels remain constant).

1. **Statewide Program for Sudden Unexpected Infant Deaths and Disparities in Infant Mortality**

    A. Support the Healthy Babies Initiative
    B. Provide professional education on evidence-based strategies to reduce the risk of sudden and unexpected infant deaths.
    C. Increase consumer education of "Back to Sleep" and safe sleep environments for infants.
    D. Provide information, counseling and grief support services to families and others who are affected by a sudden or unexpected infant death.

2. **Statewide Genetics Services**

    A. Support clinical genetics activities at outreach clinics.
    B. Explore use of telemedicine for outreaching to rural areas.
    C. Support educational programming including seminars for [professionals, families, etc.
    D. Support the establishment of an active Advisory Council for Genetics
    E. Promote the recommendations of the Statewide Genetics Plan.
    F. Encourage collaboration and statewide activities.
    G. Require data collection using SPHERE.

3. **Improve Childhood Injury Prevention with a Child Fatality Review Program**

    A. Strengthen the statewide system of child injury prevention services through a multidisciplinary collaboration of public and private sector agencies and advocates;
    B. Demonstrate a capability to identify and address emerging system improvements to assure a comprehensive statewide child injury prevention delivery system.

C. Develop statewide and local linkages among the public and private agencies to address the leading causes of childhood injury. This should include the creation or maintenance and support of state and local Child Death Review teams.
D. Conduct collaborative activities that assure the availability and acceptability of interventions that reflect state of the art injury prevention; and
E. Evaluate the program's achievement of outcome.

4. Statewide Program to Improve Maternal Health and /Reduce Disparities in Perinatal Outcomes

A. Support the Maternal Mortality Review
B. Provide education on evidence-based practices to improve maternal health and maternal care.
C. Increase risk assessment and follow-up services for women of reproductive age.
D. Promote use of folic acid among women of reproductive age.

5. Parent to Parent Matching for CSHCN

A. Increase parents' acceptance of their situation.
B. Increase parents' sense of being able to cope.
C. Promote child's health, safety, and development.
D. Prevent child abuse and neglect.

Timeline

Staff complete RFPs by March 1st.

Formally release RFPs on March 14th.

Bidder's Conference / Q&A session held on March 29th.

Grant applications due April 22nd.

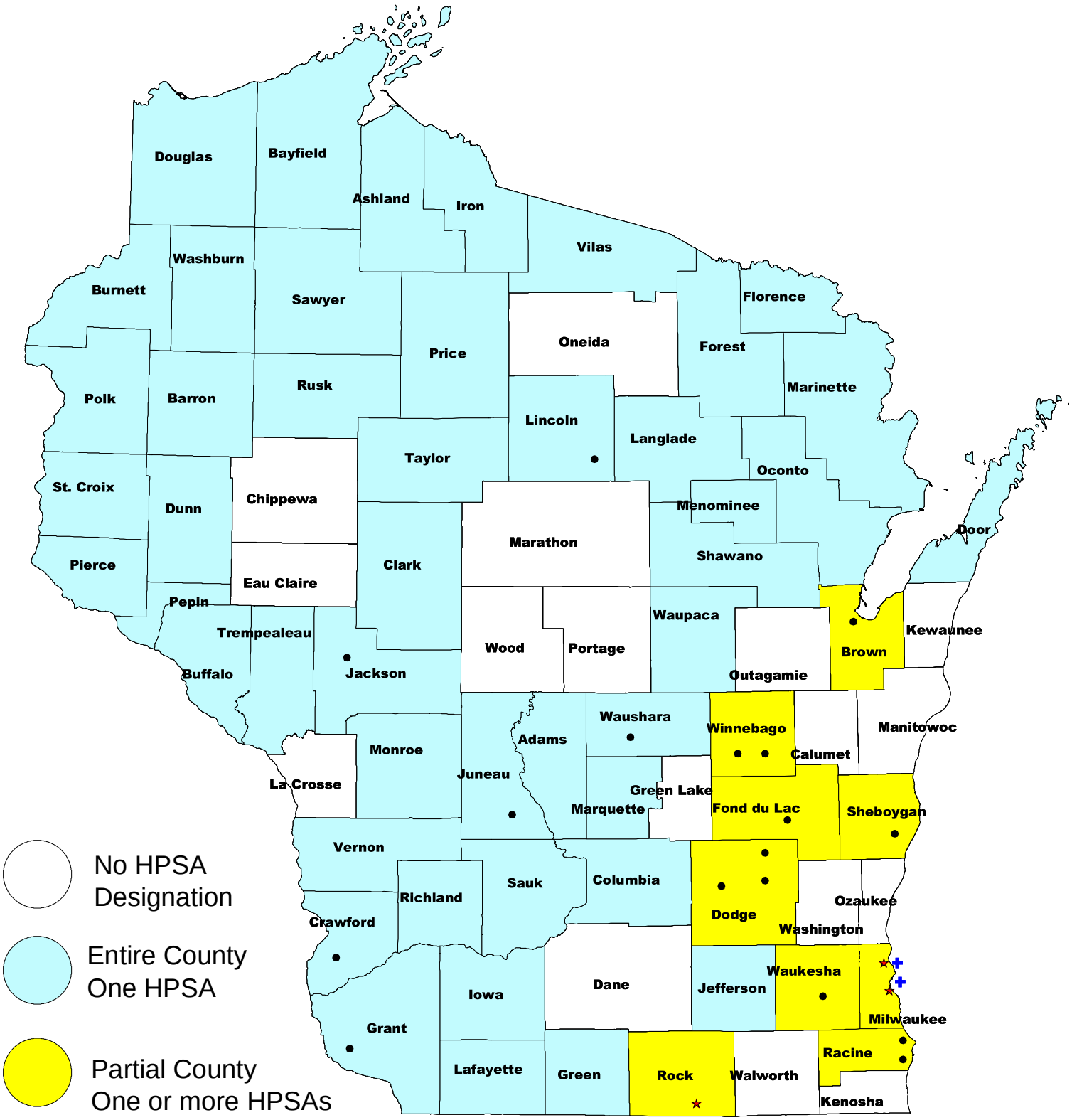
Hold Review Panel on May 6th.

DPH makes award announcement on May 23rd.

During June all appeals can take place.

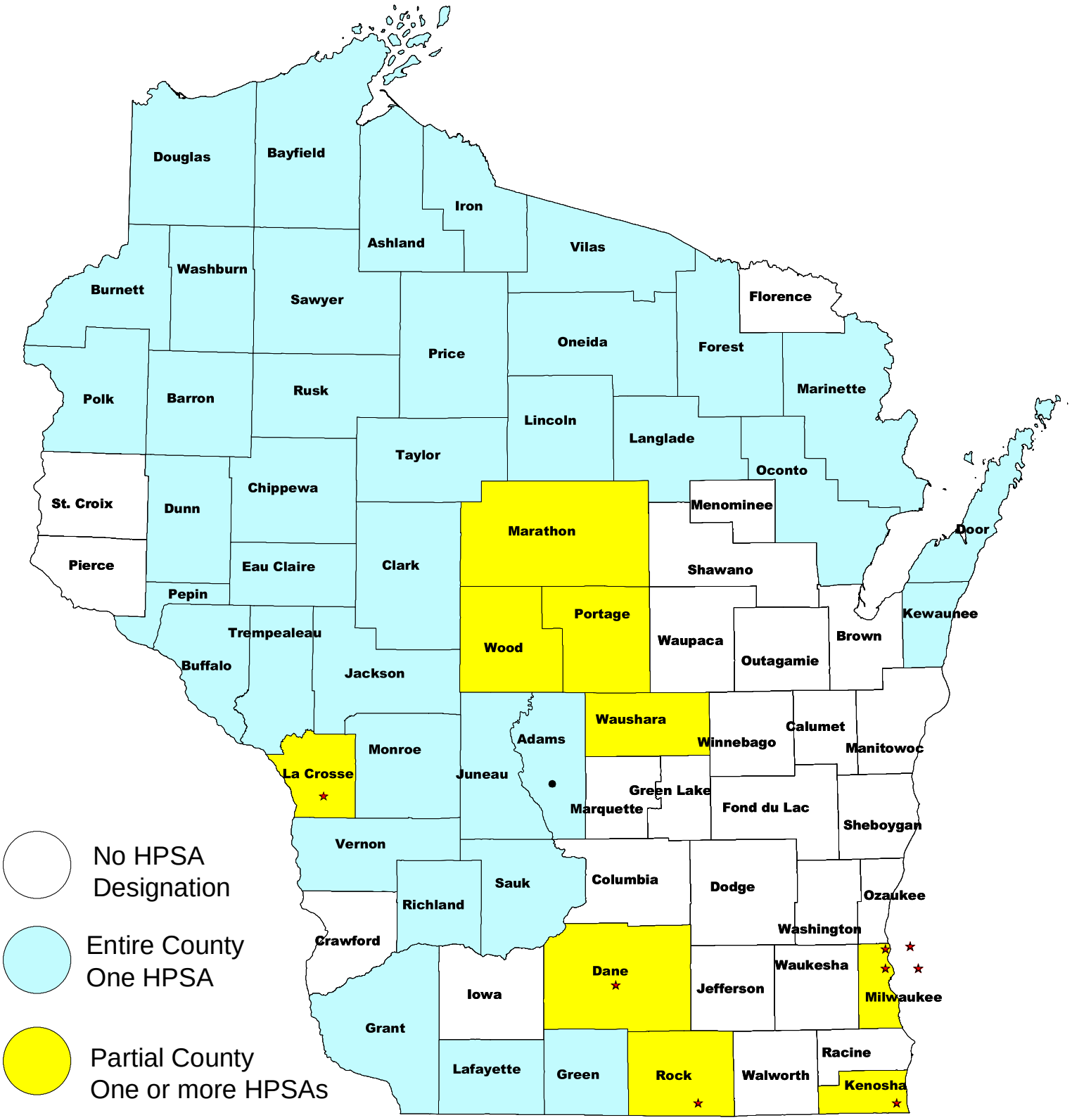
Contracts begin July 1st.

Mental Health Professional Shortage Areas (HPSAs)



Wisconsin Division of Public Health
6/4/03

Dental
Health Professional Shortage Areas (HPSAs)



No HPSA Designation

Entire County One HPSA

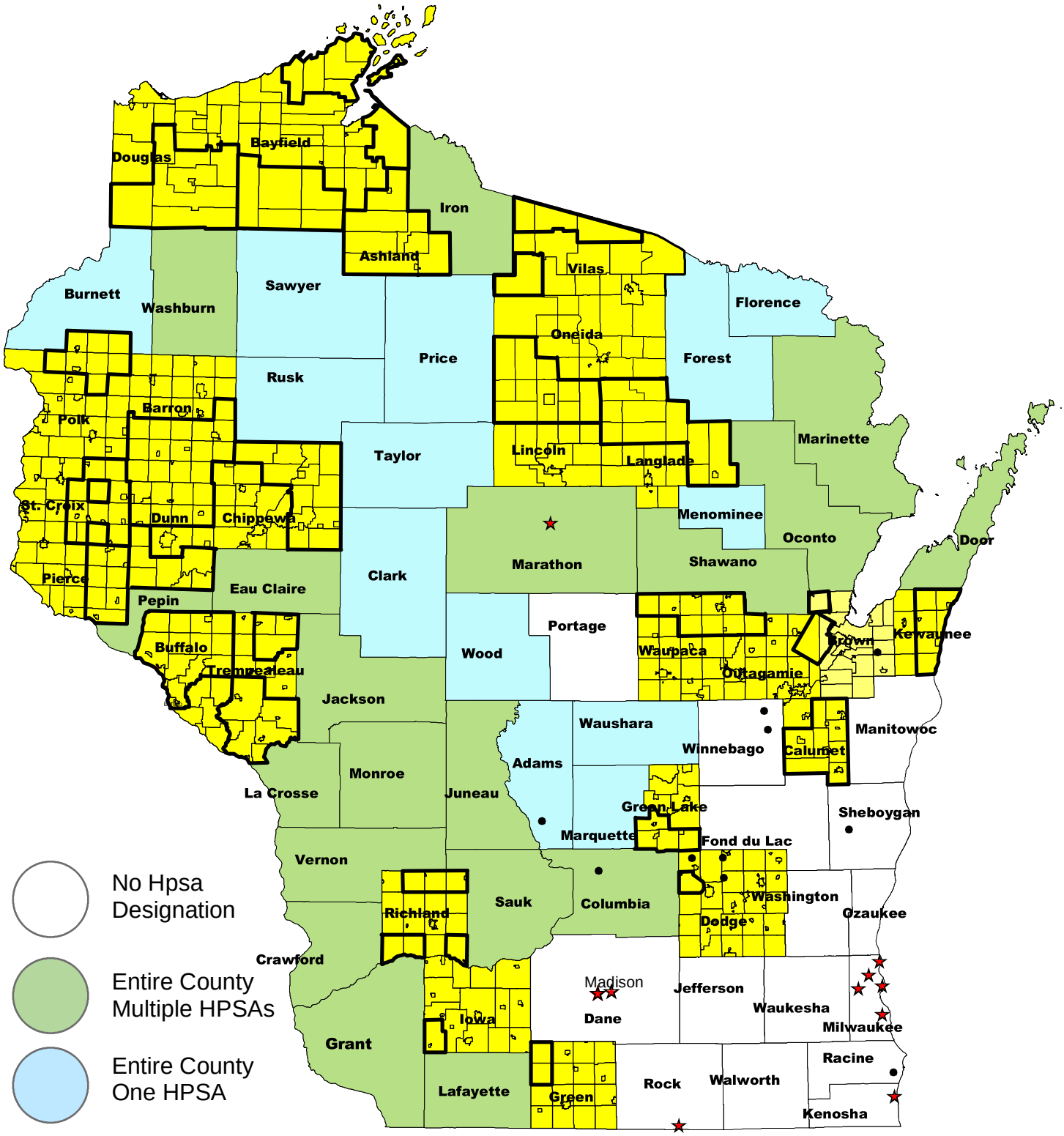
Partial County One or more HPSAs

● Correctional Facility HPSA

★ Census Tract HPSA

Wisconsin Division of Public Health
12/8/2004

Primary Care
Health Professional Shortage Areas (HPSAs)
with Townships



Wisconsin Division of Public Health
5/04

Shortage Designation Branch home page

Health Professional Shortage Areas

Ad-Hoc Database Query Selection

HPSA Data Extract as of 07/06/2005

Click Here for Query Results

Select one or more regions or states of interest, or make no selection to retrieve records for all geographic areas. You should select either one or more regions, or one or more states, but not both. If you select both specific states and specific regions, the region selections will be ignored.

County entries are ignored unless one or more states have been selected. Multiple counties may be entered, separated by commas.

You must reset the query using the [clear] button or [select new query] before beginning a new query.

Region (If selected, region is major grouping.)	All Regions Region I Region II Region III	**State** (If selected, state is major grouping.)	All States Alabama Alaska American Samoa
County			

Select HPSA characteristics to limit your search.

Discipline	Primary Medical Care Dental Mental Health	**Metro**	All Metropolitan Nonmetropolitan Frontier
Status	All Statuses Designated Withdraw n Undetermined Proposed Withdraw al Rejected No New Data	**Type**	All Types Geographic Single county Geographic Service Area Geographic Single County and Service Area Population Groups State Mental Hospitals [**Mental Health Only] Correctional Facilities
Date of Last Update	From:	To:	
HPSA Score (Lower Limit)			Submit Clear

Your search resulted in selecting 68 records.
Next Page Top of Page New Query

NAME	HPSAID	STATUS	TYPE	DISCIPLINE	METRO	UPDATED	FTE	# SHORT	SCORE	DATE OF DESIGNATION
Wisconsin										
ADAMS	155001	DESIGNATED	SCTY	PRIMARY CARE	NON-METRO	06/22/2001	2.9	2.2	17	05/30/1978
ASHLAND	155003	UNDETERMINED	SCTY	PRIMARY CARE	NON-METRO	07/30/1987	15.0	.0		
BARRON	155005		SCTY	PRIMARY CARE	NON-METRO		25.1	.0		
BAYFIELD	155007	UNDETERMINED	SCTY	PRIMARY CARE	NON-METRO	07/30/1987	3.0	.0		
BROWN	155009		SCTY	PRIMARY CARE	METRO		103.3	.0		
BUFFALO	155011		SCTY	PRIMARY CARE	NON-METRO		7.0	.0		
BURNETT	155013	DESIGNATED	SCTY	PRIMARY CARE	NON-METRO	06/22/2001	4.6	1.5	10	01/08/1981
CALUMET	155015	WITHDRAWN	SCTY	PRIMARY CARE	METRO	01/30/2001	6.9			05/30/1978
CHIPPEWA	155017		SCTY	PRIMARY CARE	METRO		28.0	.0		
CLARK	155019	DESIGNATED	SCTY	PRIMARY CARE	NON-METRO	11/19/2001	6.6	4.4	12	04/21/1978
COLUMBIA	155021	WITHDRAWN	SCTY	PRIMARY CARE	NON-METRO	08/10/2000	10.7			08/12/1994
CRAWFORD	155023		SCTY	PRIMARY CARE	NON-METRO		11.0	.0		
DANE	155025		SCTY	PRIMARY CARE	METRO		341.4	.0		
DODGE	155027		SCTY	PRIMARY CARE	NON-METRO		32.0	.0		
DOOR	155029		SCTY	PRIMARY CARE	NON-METRO		16.0	.0		
DOUGLAS	155031	UNDETERMINED	SCTY	PRIMARY CARE	METRO	07/30/1987	16.0	.0		
DUNN	155033		SCTY	PRIMARY CARE	NON-METRO		14.0	.0		
EAU CLAIRE	155035		SCTY	PRIMARY CARE	METRO		64.2	.0		
FLORENCE	155037	DESIGNATED	SCTY	PRIMARY CARE	NON-METRO	04/14/2005	1.0	.4	13	03/31/1995
FOND DU LAC	155039		SCTY	PRIMARY CARE	NON-METRO		50.0	.0		
FOREST	155041	DESIGNATED	SCTY	PRIMARY CARE	NON-METRO	04/26/2005	2.6	.2	9	11/06/1990
GRANT	155043	WITHDRAWN	SCTY	PRIMARY CARE	NON-METRO	03/26/1984	17.0			06/12/1978
GREEN	155045		SCTY	PRIMARY CARE	NON-METRO		30.0	.0		
GREEN LAKE	155047		SCTY	PRIMARY CARE	NON-METRO		10.1	.0		
IOWA	155049	WITHDRAWN	SCTY	PRIMARY CARE	NON-METRO	03/26/1984	9.0			06/12/1978
IRON	155051	UNDETERMINED	SCTY	PRIMARY CARE	NON-METRO	07/30/1987	4.0	.0		
JACKSON	155053		SCTY	PRIMARY CARE	NON-METRO		8.0	.0		
JEFFERSON	155055		SCTY	PRIMARY CARE	NON-METRO		36.2	.0		
JUNEAU	155057		SCTY	PRIMARY CARE	NON-METRO		9.0	.0		
KENOSHA	155059		SCTY	PRIMARY CARE	METRO		56.5	.0		

KEWAUNEE	155061		SCTY	PRIMARY CARE	NON-METRO		8.0	.0		
LA CROSSE	155063		SCTY	PRIMARY CARE	METRO		95.8	.0		
LAFAYETTE	155065	WITHDRAWN	SCTY	PRIMARY CARE	NON-METRO	11/02/1984	4.0			06/12/1978
LANGLADE	155067		SCTY	PRIMARY CARE	NON-METRO		12.0	.0		
LINCOLN	155069		SCTY	PRIMARY CARE	NON-METRO		17.0	.0		
MANITOWOC	155071		SCTY	PRIMARY CARE	NON-METRO		38.1	.0		
MARATHON	155073		SCTY	PRIMARY CARE	METRO		63.1	.0		
MARINETTE	155075		SCTY	PRIMARY CARE	NON-METRO		25.0	.0		
MARQUETTE	155077	DESIGNATED	SCTY	PRIMARY CARE	NON-METRO	05/26/2005	2.0	1.9	15	11/09/2000
MILWAUKEE	155079		SCTY	PRIMARY CARE	METRO		796.7	.0		
MONROE	155081		SCTY	PRIMARY CARE	NON-METRO		14.0	.0		
OCONTO	155083		SCTY	PRIMARY CARE	NON-METRO		12.0	.0		
ONEIDA	155085		SCTY	PRIMARY CARE	NON-METRO		28.2	.0		
OUTAGAMIE	155087		SCTY	PRIMARY CARE	METRO		82.9	.0		
OZAUKEE	155089		SCTY	PRIMARY CARE	METRO		39.3	.0		
PEPIN	155091	WITHDRAWN	SCTY	PRIMARY CARE	NON-METRO	03/26/1984	2.0			03/02/1982
PIERCE	155093		SCTY	PRIMARY CARE	METRO		18.0	.0		
POLK	155095		SCTY	PRIMARY CARE	NON-METRO		24.2	.0		
PORTAGE	155097		SCTY	PRIMARY CARE	NON-METRO		30.1	.0		
PRICE	155099559U	DESIGNATED	SCTY	PRIMARY CARE			4.7	.0		09/10/2001
RACINE	155101		SCTY	PRIMARY CARE	METRO		89.2	.0		

Next Page Beginning of Query Results Top of Page New Query

Wisconsin J-1 Visa Waiver Program

J-1 Visa Waiver: General Information

The Wisconsin J-1 visa waiver program increases access to primary health and mental health care in rural and urban communities that have shortages of primary care physicians and psychiatrists, by helping medical clinics recruit foreign physicians. Qualified foreign physicians must have completed their advanced clinical training in an approved U.S. residency training program, must agree to work in the shortage area for three years, and must increase access to primary health care.

Between 1995 and 2000, the Wisconsin J-1 visa waiver program helped medical clinics recruit more than 100 foreign physicians to increase access to primary care and general mental health care in rural and urban shortage areas throughout the state. This program is coordinated with the U.S. Department of State and the Immigration and Naturalization Service.

Last Revised: January 5 2005

Wisconsin

44 Data Detail

Sheets

Pages 1 through 92

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Infant mortality

DEFINITION

Number of deaths to live born infants prior to the first birthday in a calendar year, per 1,000 live births in that year.

DESCRIPTION OF THE NEED

In 2003, 454 Wisconsin infants under the age of one year died. In 2003, Wisconsin's overall infant mortality rate was 6.5; the Black rate was 15.3 and the White rate was 5.3, a ratio of 2.9. The Hispanic rate was 6.9.[1]

Annual rates are not usually calculated for groups with fewer than 20 deaths a year; and in Wisconsin, American Indians and Laotian/Hmong are two groups that usually have fewer than 20 infant deaths in a year. Therefore, their infant mortality rates are calculated for three-year periods. American Indians (12.9 for 2001-2003) have the next highest infant mortality rates (after Blacks), followed by Laotian/Hmong (7.6 for 2001-2003).[2]

SERIOUSNESS OF THE PROBLEM

In Wisconsin, aside from minor fluctuations, Wisconsin's Black infant mortality rate has remained largely unchanged for the past two decades. Because Black infant mortality in other states has improved during this time period, Wisconsin's ranking has dropped considerably, and its Black infant mortality rate is one of the worst in the country. In fact, from 1979-1981 the U.S. infant mortality rate dropped dramatically from 21.9 in 1979-1981 to 13.7 in 1999-2001. Yet, in Wisconsin, during the same time period, little decline occurred (19.3 in 1979-1981 to 16.9 in 1999-2001). A lower than average black infant mortality rate in 1979-1981 placed Wisconsin as the 3rd best state (n=34) for infant mortality, but in 1999-2001, Wisconsin was among the worst states, ranking 32 among 34.[3]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Fetal, Infant, Child Deaths

Title V State Performance Measure:

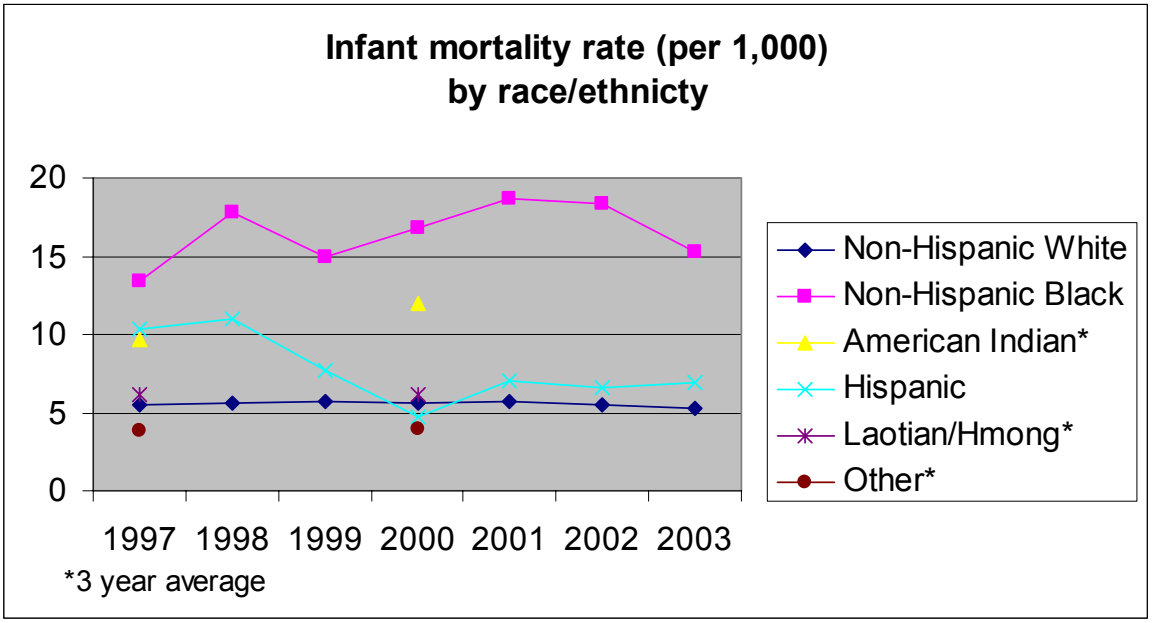
Ratio of black infant mortality rate to the white mortality rate

DATA DEPICTION

Wisconsin: Infant mortality rates by race[1,2]

Race / Ethnicity	1997	1998	1999	2000	2001	2002	2003
Non-Hispanic White	5.5	5.6	5.7	5.6	5.7	5.5	5.3
Non-Hispanic Black	13.4	17.8	14.9	16.8	18.7	18.3	15.3
American Indian	--	8.4*			12.9*		
Hispanic	10.3	11.0	7.7	4.7	7.0	6.6	6.9
Laotian/Hmong	--	6.7*			7.6*		
Other	--	3.6*			5.3*		
Total	6.5	7.2	6.7	6.6	7.1	6.8	6.5

*3 year average



REFERENCES

[1] Wisconsin Department of Health and Family Services, Divison of Public Health, Bureau of Health Information and Policy. ***Wisconsin Births and Infant Deaths, 2003*** (PPH 5364-03). October 2004.

[2] Wisconsin Department of Health and Family Services, Divison of Public Health, Bureau of Health Information WISH (Wisconsin Interactive Statistics on Health), http//dhfs.wisconsin.gov/wish/, Infant Mortality Module, accessed 03/16/05.

[3] Kvale, KM, Mascola MA, Glysch RL, Kirby RS, Katcher ML. Trends in Maternal and Child Health Outcomes: Where Does Wisconsin Rank in the National Context. *Wis Med J.* 2004, 103(5):42-47.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Low birthweight and prematurity

DEFINITION

Low birthweight: Percent of live births with birthweights less than 2,500 grams (5 pounds, 8 ounces) during a calendar year. Prematurity: Percent of live births born with a gestation of less than 37 weeks.

DESCRIPTION OF THE NEED

In 2003, 4,773 Wisconsin infants were low birthweight, weighing less than 2,500 grams (5 pounds, 8 ounces) at birth.[1] This total represented 6.6% of all births or 1 in 15 babies; black infants (13.2%) were about 2 times as likely as white infants (5.8%) to be born low birthweight. Compared with singleton births, multiple births in Wisconsin were about 10 times as likely to be low birthweight in 2003. Also, in 2003, 7,696 Wisconsin (11.0%) infants were born prematurely, with a gestation of less than 37 weeks. [1] Higher percentages of premature infants are born to non-Hispanic black women (16.7%), teenagers less than 18 (15.9%), unmarried women (13.0%), women who smoked during pregnancy (12.6%), women with less than a high school education (12.3%), and Laotian/Hmong women (11.5%).[1]

Major risk factors for low birthweight and prematurity include: multiple births, preterm delivery, smoking, inadequate maternal nutrition, maternal age extremes, and short inter-pregnancy interval. Low birthweight and premature infants are more likely to die during their first year of life than normal birthweight babies.

SERIOUSNESS OF THE PROBLEM

An infant's birthweight is one of the most important predictors of his/her's health and survival during the first year of life. LBW infants are at least 20 times more likely to die than heavier babies; VLBW (3 pounds, 5 ounces) and LBW infants are more likely to suffer long-term illnesses and neurologic and developmental disabilities.[2] In Wisconsin, rates of LBW among white infants have been consistently lower than national averages, while corresponding rates for black infants have been slightly higher in Wisconsin than in the US, overall. The rate of LBW among black infants is consistently twice as high as that of white infants.[3] The cost-effectiveness of early and adequate prenatal care as a method to prevent or reduce LBW and pre-term births is well-documented. In 1999, the CDC estimated a savings of $14,775 (US $1,984) per LBW birth prevented if all women received adequate prenatal care.[4] A 1999 study estimated that the median total treatment costs for VLBW infants ranged from $31,531 to $49,457 with the smallest infants incurring the largest costs.[5] Hospital charges related to LBW and premature births average $75,000 per child (compared to $1,300 for newborns without complications) and national costs were estimated at $13.6 billion in 2001.[6]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Obstetrical Care
Risk Factors

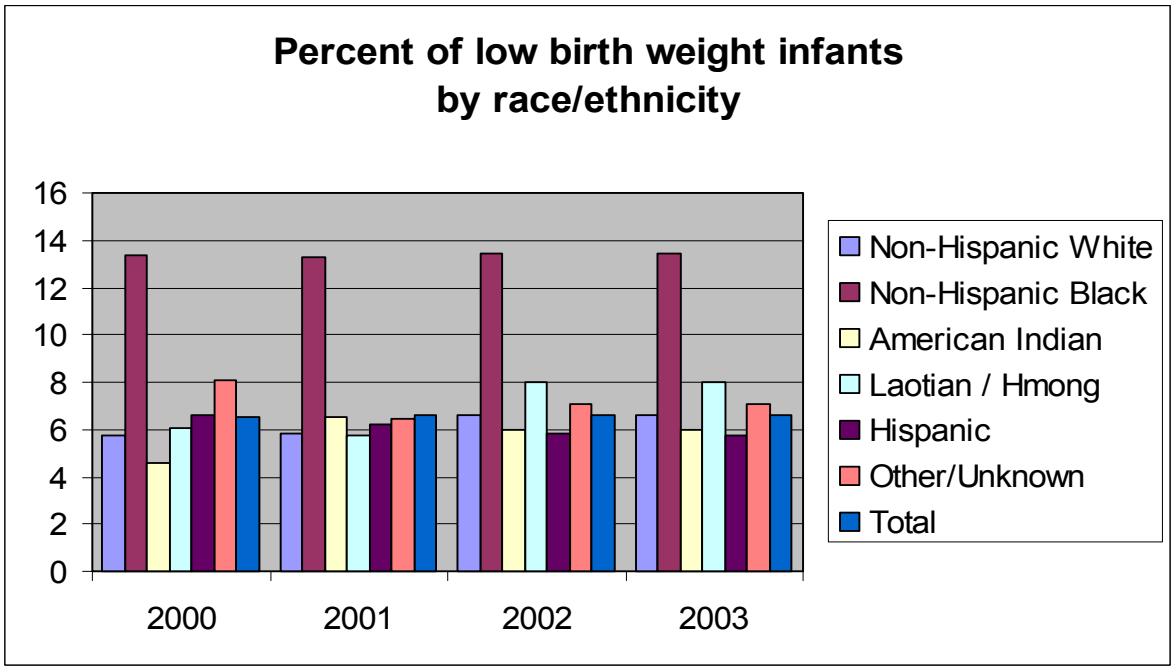
Title V National Performance Measure:

Percent of very low birthweight infants among all live births
Percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates

DATA DEPICTION

Wisconsin: Percent of low birthweight and premature births, 2000-2003[2]

Year	2000		2001		2002		2003	
Race / Ethnicity	LBW	Prem	LBW	Prem	LBW	Prem	LBW	Prem
White Non-Hispanic	5.8%	9.6%	5.9%	10.0%	6.6%	9.9%	6.1%	10.4%
Black Non-Hispanic	13.3%	17.4%	13.3%	17.1%	13.4%	16.9%	13.7%	16.7%
American Indian	4.6%	9.7%	6.6%	10.9%	6.0%	10.7%	6.3%	11.3%
Laotian/Hmong	6.0%	12.5%	5.7%	11.3%	8.0%	14.1%	7.4%	11.5%
Hispanic	6.6%	10.2%	6.2%	10.2%	5.8%	9.9%	6.2%	10.4%
Other /Unknown	8.1%	9.0%	6.4%	9.9%	7.1%	10.0%	7.9%	9.6%
Total	6.5%	10.4%	6.6%	10.8%	6.6%	10.7%	6.8%	11.0%



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[2] MacDorman MF, Minino AM et al. Annual summary of vital statistics-2001. *Pediatrics*. 2002. 110(6):1037-1052.

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[5] Rogowski J. Measuring the cost of neonatal and perinatal care. *Pediatrics*. 1999. 103(1):329-335.

[6] National Governor's Association. Center for Best Practices. Healthy Babies: Efforts to Improve Birth Outcomes and Reduce High-risk Births. June 2004.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

First trimester prenatal care

DEFINITION

Percent of mothers who give live birth and receive prenatal care beginning in the first trimester during the calendar year.

DESCRIPTION OF THE NEED

The overall proportion of women in Wisconsin who received first-trimester prenatal care was 84.7% in 2003. Among Black and American Indian women, 73.5% and 71.0% respectively, received prenatal care during the first trimester, compared to 88.3% for White women; followed by Hispanic women with 71.0%, and Laotian/Hmong with 54.2%.[1]

SERIOUSNESS OF THE PROBLEM

Early entry into prenatal care continuing during the pregnancy reduces the risk of behavioral risk factors (poor nutrition, substance abuse), adverse birth outcomes (prematurity, low birthweight, and infant mortality), and prevents complications of pregnancy (placenta previa and infection), and maternal morbidity.[2] In 2002, Wisconsin's overall rate of prenatal care of 84.3% compared favorably to the US rate of 83.7%.[3] However, there are disparities between racial and ethnic groups in the percent of mothers receiving first trimester prenatal care: in 2002, 75.2% of US African American women received first trimester prenatal care compared to 71.4% of Wisconsin African American women; 76.7% of US Hispanic women received first trimester prenatal care, compared to 69.4% of Wisconsin Hispanic women.[3]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:
Prenatal Care

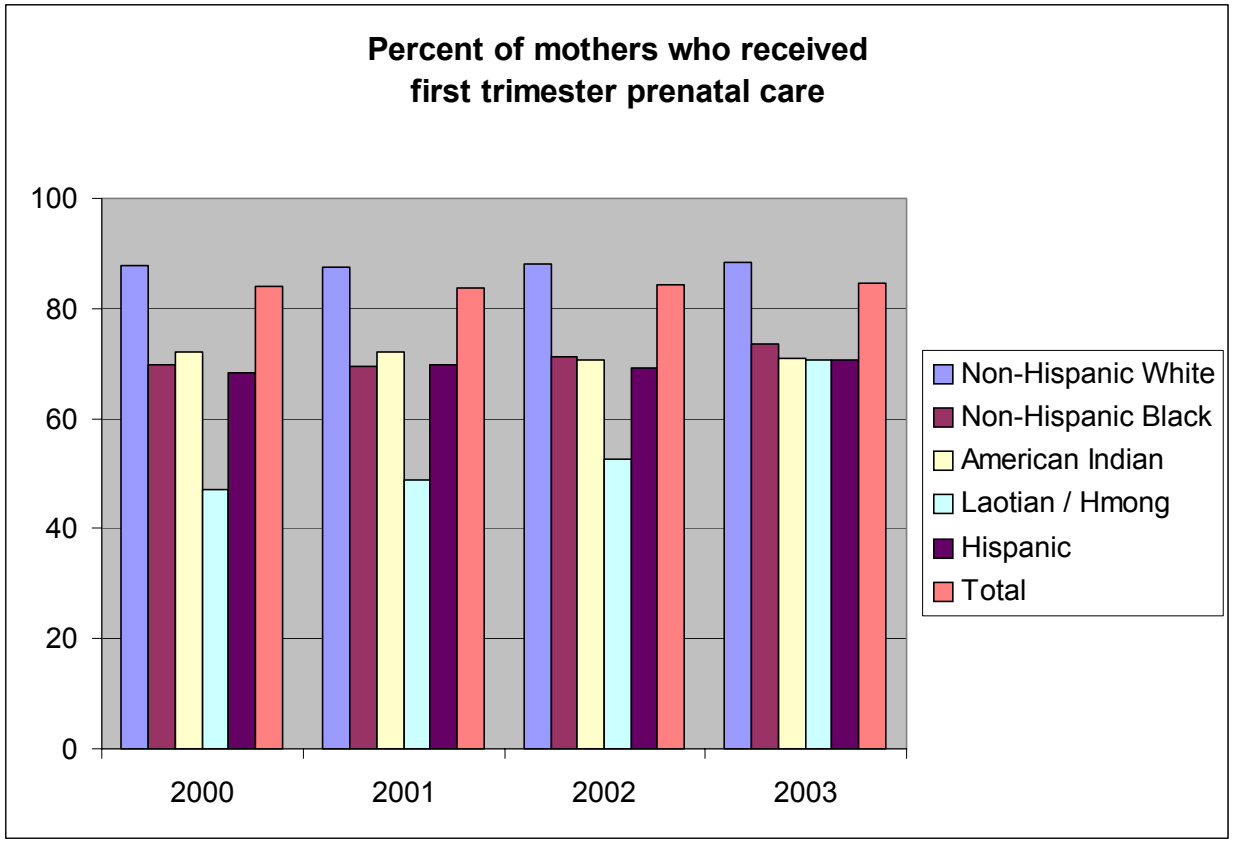
Healthiest Wisconsin 2010 Health Priority:
Access to Primary and Preventive Health Services

Title V National Performance Measure:
Percent of infants born to pregnant women receiving prental care beginning in the first trimester

DATA DEPICTION

Wisconsin: Percent of women who gave live birth and received first trimester prenatal care[4]

Race / Ethnicity	2000	2001	2002	2003
Non-Hispanic White	87.7%	87.6%	88.1%	88.3%
Non-Hispanic Black	69.7%	69.4%	71.3%	73.5%
American Indian	72.0%	72.2%	70.7%	71.0%
Laotian/Hmong	47.2%	48.9%	52.5%	54.2%
Hispanic	68.4%	69.6%	69.2%	70.5%
Other/Unknown	83.9%	85.2%	81.8%	81.9%
Total	83.9%	83.7%	84.2%	84.7%



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[4] Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Prenatal Care Module, accessed 09/27/2004.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Sudden Infant Death Syndrome (SIDS)

DEFINITION

The sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history (Willinger, et al., 1991).[1]

DESCRIPTION OF THE NEED

SIDS is the leading cause of deaths for infants, from 1 month to 1 year, with most deaths occuring between 2 and 4 months. Since the Back to Sleep Campaign was launched in 1994, the rate of SIDS deaths has decreased dramatically. However, there are still significant differences among racial and ethnic minorities.[1]

NATIONAL / STATE GOAL

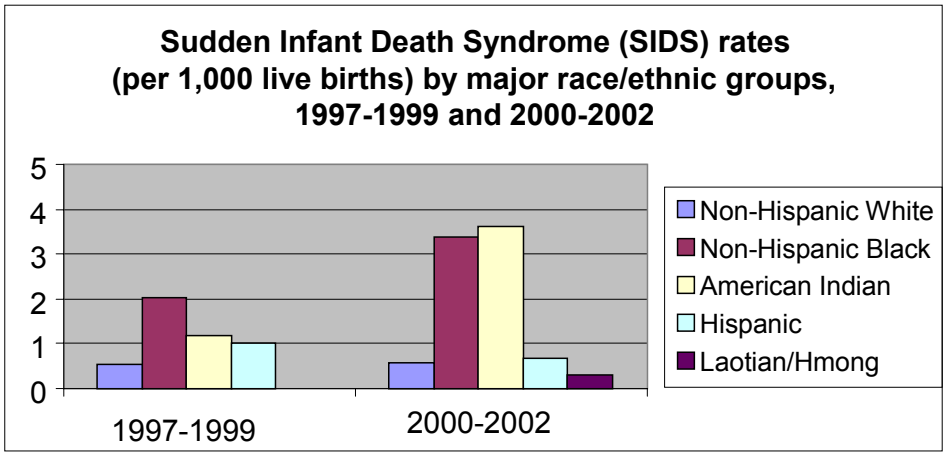
Healthy People 2010 Chapter:

Fetal, Infant, and Child Deaths

DATA DEPICTION[2]

Rate of SIDS per 1,000 live births

Race / Ethnicity	1997-1999	2000-2002
Non-Hispanic White	0.54	0.56
Non-Hispanic Black	2.02	3.38
American Indian		3.62
Hispanic	1.01	.67
Laotian/Hmong		
Total	.72	.87



DATA SOURCE

[1] http://www.sidscenter.org/Downloads/S148.htm accessed 10/26/04.

[2] Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information, Wisconsin Interactive Statistics on Health (WLSH), http://dhfs.wisconsin.gov/wish/ Infant Mortality Module, accessed 10/27/04.

(11/05/04)

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Newborn hearing screening

DEFINITION

Percent of newborns who receive screening for hearing loss prior to discharge from the birth hospital.

DESCRIPTION OF THE NEED

Hearing loss is the most common congenital birth defect affecting Wisconsin infants. Every year, an estimated 200 babies are born in Wisconsin with hearing impairment, based on an estimated prevalence rate of three newborns per 1,000 with permanent congenital hearing loss greater than 25 dBHL. Studies show that if hearing loss is identified and intervention services are administered prior to six months of age, children who are deaf or hard of hearing have the potential to develop communication and cognition skills similar to their hearing peers. The Joint Committee on Infant Hearing, National Institutes of Health, and the American Academy of Pediatrics endorse early hearing detection and intervention for infants with hearing loss through integrated, interdisciplinary state and national systems of universal newborn hearing screening, identification, and family-centered intervention.[1]

Establishment of universal newborn hearing screening (UNHS) programs at Wisconsin hospitals has been voluntary. However, the impetus behind this voluntary implementation was a directed legislative effort to encourage the establishment of programs. In 1999, the Wisconsin Legislature established by statute that if, by August 5, 2003, the Department of Health and Family Services determined that fewer than 88% of all deliveries in the state are performed in hospitals that have a newborn hearing screening program, every hospital shall, by January 1, 2004, have a newborn hearing screening program (Section 2439r, 253.115).

In 1999, only 28% of newborns were screened for hearing loss prior to discharge. In 2003, 95% of Wisconsin newborns were screened prior to discharge. It is not only critical that all Wisconsin babies be screened, but all newborns who do not pass screening must receive diagnostic audiology services by 3 months of age. All infants diagnosed as deaf or hard of hearing are referred to Birth to 3 services by 6 months of age.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Hearing

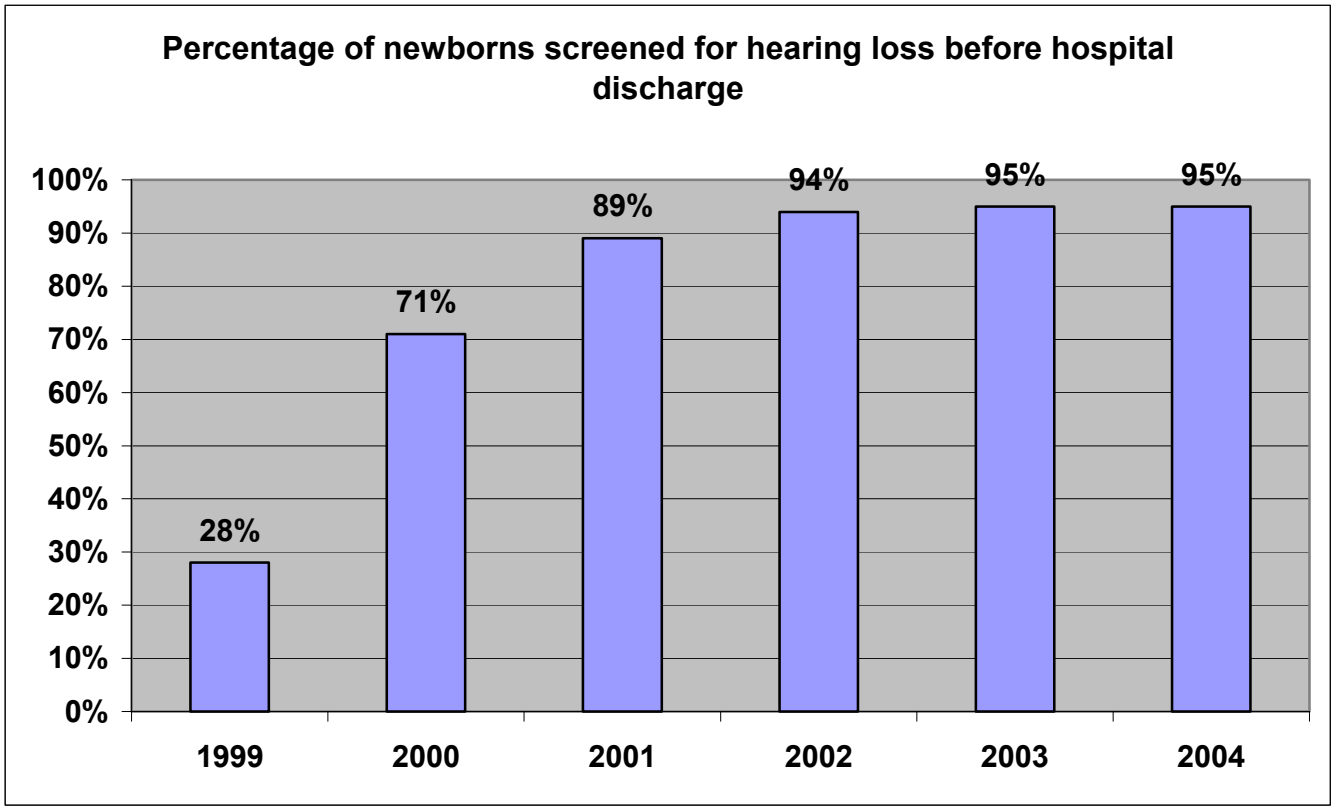
Title V National Performance Measure:

Percent of newborns who have been screened for hearing before hospital discharge

DATA DEPICTION[2]

Percent of Newborns Screened for Hearing Loss before Hospital Discharge

1999	2000	2001	2002	2003	2004
28%	71%	89%	94%	95%	95%



DATA SOURCE

[1] 2000 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs. *Pediatrics*. 2000; 106:798-817.

[2] Data derived from the State and Local Area Integrated Telephone Survey (SLAITS), National Survey of Children with Special Health Care Needs (CSHCN), conducted by CDC-NCHS in 2000 – 2002. Percents are weighted.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Breastfeeding initiation and duration

DEFINITION

Percent of infants enrolled in the WIC Program who were breastfed initally, breastfed at 6 months and at 12 months.

DESCRIPTION OF THE NEED

The nutritional, allergenic, immunologic, economic and psychologic advantages of breastfeeding are well recognized. Data for this indicator are collected on all infants enrolled in the Wisconsin Supplemental Nutrition Program for Women, Infants and Children (WIC) and reported in the Wisconsin Pediatric Nutrition Surveillance System (PedNSS). The data represents over 50% of all infants born in Wisconsin including approximately 80% of all minority births. In the 2002 PedNSS, 55% of the infants were initially breastfed, 22.6% breastfed for at least 6 months and 14.9% were breastfed for at least 12 months. The prevalence of breastfeeding for infants in the PedNSS has increased more than 10% from the 1994 rate of 44.8% to the 2002 rate of 55%. Improved breastfeeding rates are evident among all racial and ethnic groups. In Wisconsin, Hispanic infants were most likely to be initially breastfed (72%), followed by American Indian (60%), White (58%), Black (40%), and Asian (37%)[1].

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Breastfeeding, Newborn Screening, and Service Systems

Healthiest Wisconsin 2010 Health Priority:

Adequate and Appropriate Nutrition
Overweight Obesity and Lack of Physical Activity

Title V National Performance Measure:

Percent of mothers who breastfeed their infants at hospital discharge

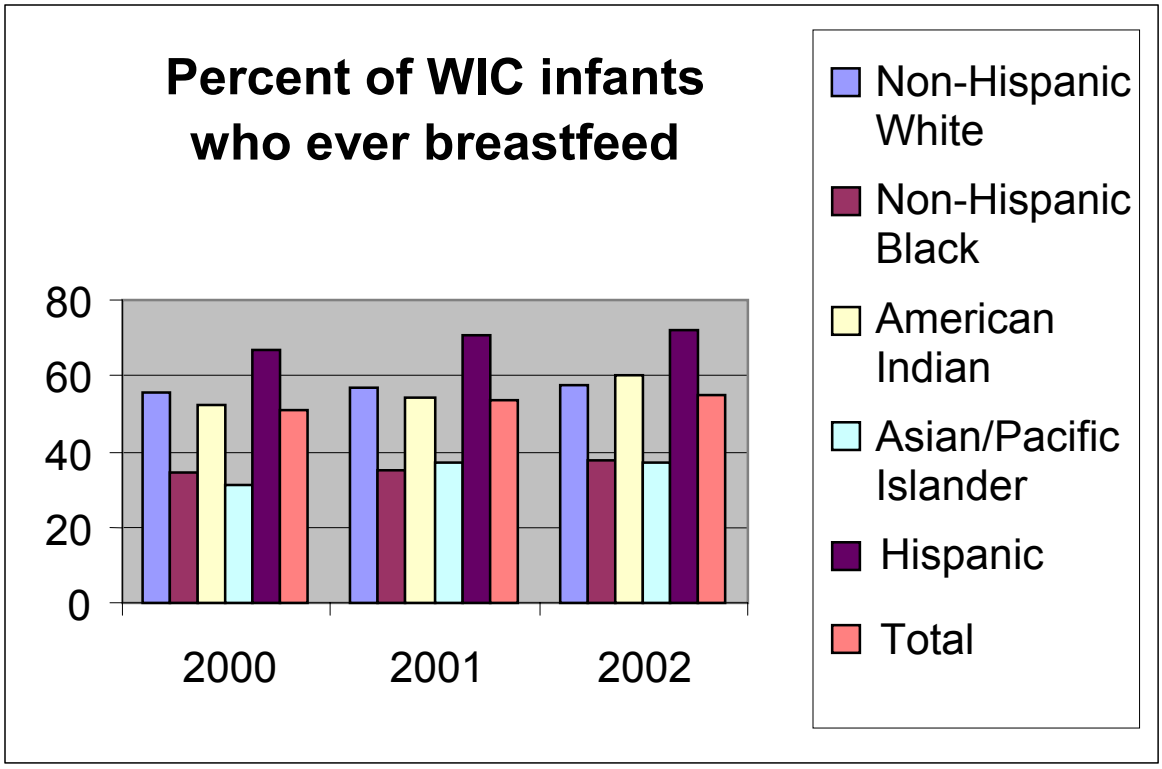
Title V State Performance Measure:

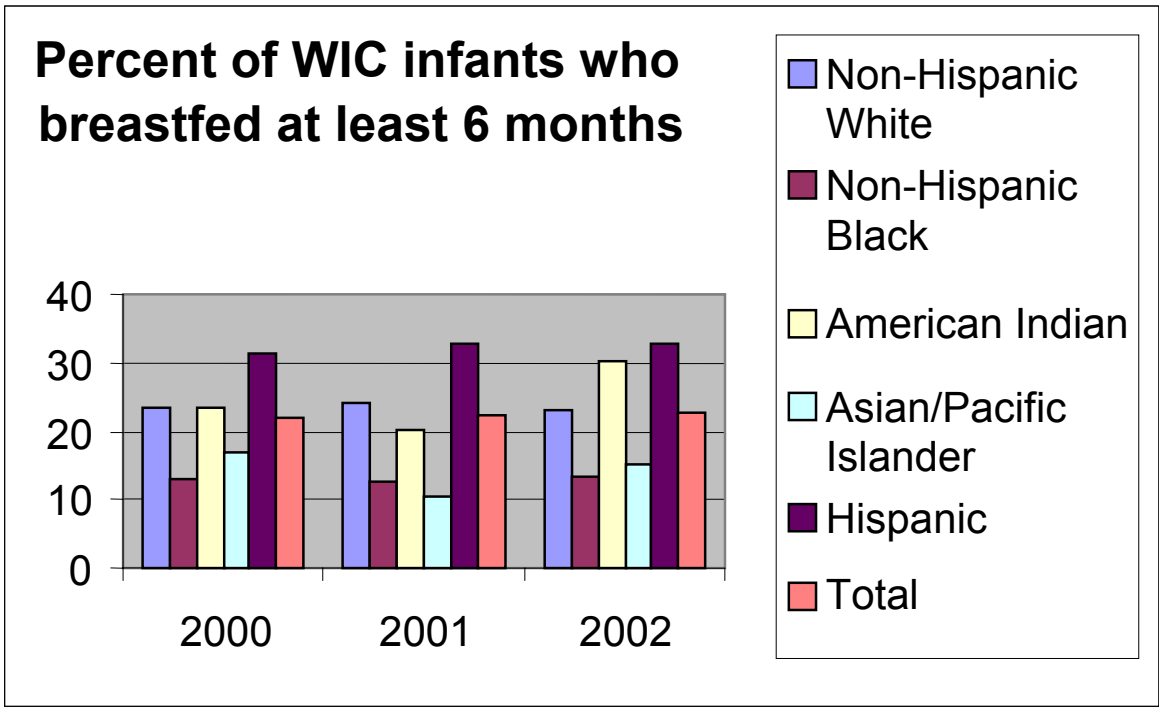
Percent of women enrolled in WIC during pregnancy that initiated breastfeeding

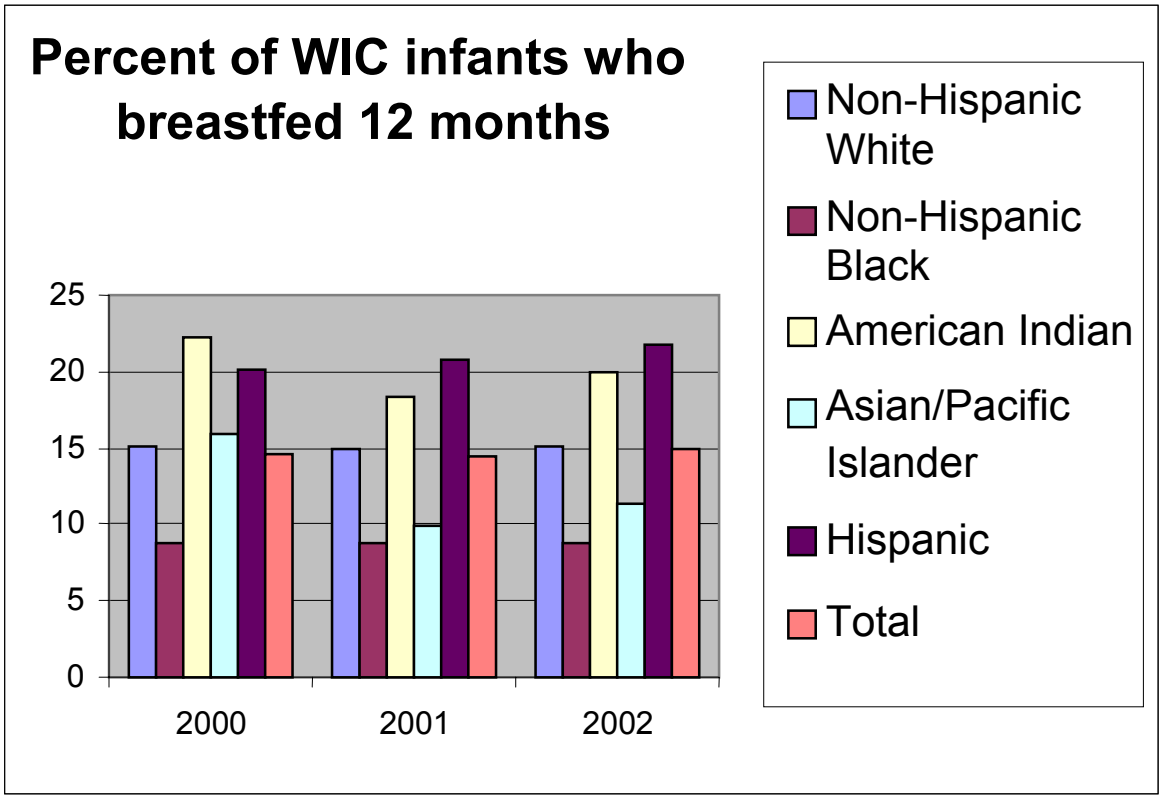
DATA DEPICTION[2], [3], [4]

Percent of infants enrolled in the WIC Program who were breastfed.

Infants Breastfed	Ever breastfed			Breastfed at least 6 months			Breastfed 12 months		
	2000	2001	2002	2000	2001	2002	2000	2001	2002
Non-Hispanic White	55.4%	56.9%	57.6%	23.4%	24.3%	23.1%	15.1%	15.0%	15.1%
Non-Hispanic Black	34.3%	35.1%	37.9%	13.0%	12.5%	13.5%	8.7%	8.8%	8.8%
American Indian	52.3%	54.5%	60.0%	23.5%	20.1%	30.1%	22.2%	18.4%	19.9%
Asian/Pacific Islander	31.1%	37.1%	37.0%	17.1%	10.6%	15.3%	15.9%	9.9%	11.3%
Hispanic	67.0%	70.6%	72.3%	31.3%	32.9%	32.8%	20.2%	20.8%	21.7%
Total	51.0%	53.4%	55.0%	22.1%	22.5%	22.6%	14.6%	14.4%	14.9%







DATA SOURCE

[1] Pediatric Nutrition Surveillance, 2001 Report, U.S. Department of Health and Human Services, 2003.

[2] 2002 Pediatric Nutrition Surveillance System, Centers for Disease Control and Prevention, Table 19C.

[3] Supplementary data: Ross Mother's Survey. Abbot Laboratories, Ross Products Division.

[4] National Immunization Survey, Centers for Disease Control, 2003.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

New parent home visitation

DEFINITION

The home visit will provide all first-time parents with basic information about nutrition, care of the newborn, emergency services, and programs for which they may be eligible.[1]

DESCRIPTION OF THE NEED

In KidsFirst, the Governor proposed a universal system of voluntary home visits to offer parent education to every new parent in Wisconsin, with appropriate follow-up and referrals to available services.[1] Currently, 41 of 72 counties (57%) offer some form of home visiting for young families. Of these, nearly three quarters (32 counties) offer a one-time visit for first-time birth parents that is a basic health assessment by a public health nurse. Thirty-one counties (43%) do not offer home visiting.[2]

A pilot program operating for first-time parents on Medical Assistance in nine counties offers a comprehensive home visiting program for up to three years. The comprehensive program offered weekly, bi-monthly, monthly, and quarterly home visits to families based on the family need for continued support and services. This allowed the time and frequency to address several family issues including parent leadership in maintaining a stable home, parent-child relationships, and referral and use of available community resources. Preliminary data from the pilot program demonstrated that children in the program were far more likely to get their medical exams and vaccinations on time compared to other children on Medical Assistance. These families also made fewer trips to the emergency room, were less likely to have reports of abuse and neglect, and had fewer placements in foster care.

NATIONAL / STATE GOAL

Healthiest Wisconsin 2010 Health Priority:

Access to Primary and Preventive Health Services

Title V State Performance Measure:

Percent of MCH clients/families who receive one or more supportive services to enhance child health, development, and/or safety

DATA DEPICTION

Data is not available.

DATA SOURCE

[1] KidsFirst: The Governor's Plan to Invest in Wisconsin's Future, 2003.

[2] Unpublished survey of Wisconsin counties.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Women's mental health

DEFINITION

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity.[1]

DESCRIPTION OF THE NEED

Women have an approximately 2 times greater rate of major depression than men, and lifetime incidence of a major depressive diagnosis is 20% in women and 12% in men.[2] Overall, women are more likely than men to have a diagnosis of depression, and more Wisconsin women than men were hospitalized for depression—mirroring national trends. Indicators such as the percentage of women with depression who receive treatment, are measured nationally, but no Wisconsin state-level data is available. Uniform availability of mental health data for the women of Wisconsin is needed.[3] Statewide, suicide was the second leading cause of death in the age group 15 to 24 years. Males are more likely to succeed in a suicide attempt than females, but females are more likely to attempt suicide.[4]

SERIOUSNESS OF THE PROBLEM

- CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) data for seven states showed that, in 2000, 7.1% of women who gave birth to a live infant reported severe depression after delivery and more than half reported low to moderate depression.[5]
- The National Women's Law Center state-by-state report card showed that 47.8% of Wisconsin women reported they have had bad mental health days in the last 30 days, versus only 37.3% of women nationwide.[6]
- American Indian women had the highest overall rates of hospitalization for depression in Wisconsin—1.7 times greater than the rate for all women hospitalized for depression.[7]
- The National Health Interview Study for 2002 reported that 3.4% of women ages 18-44, 4.5% of women 45-64 and 2.4% of women 65 and older experienced serious psychological distress during the last 30 days.[8]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

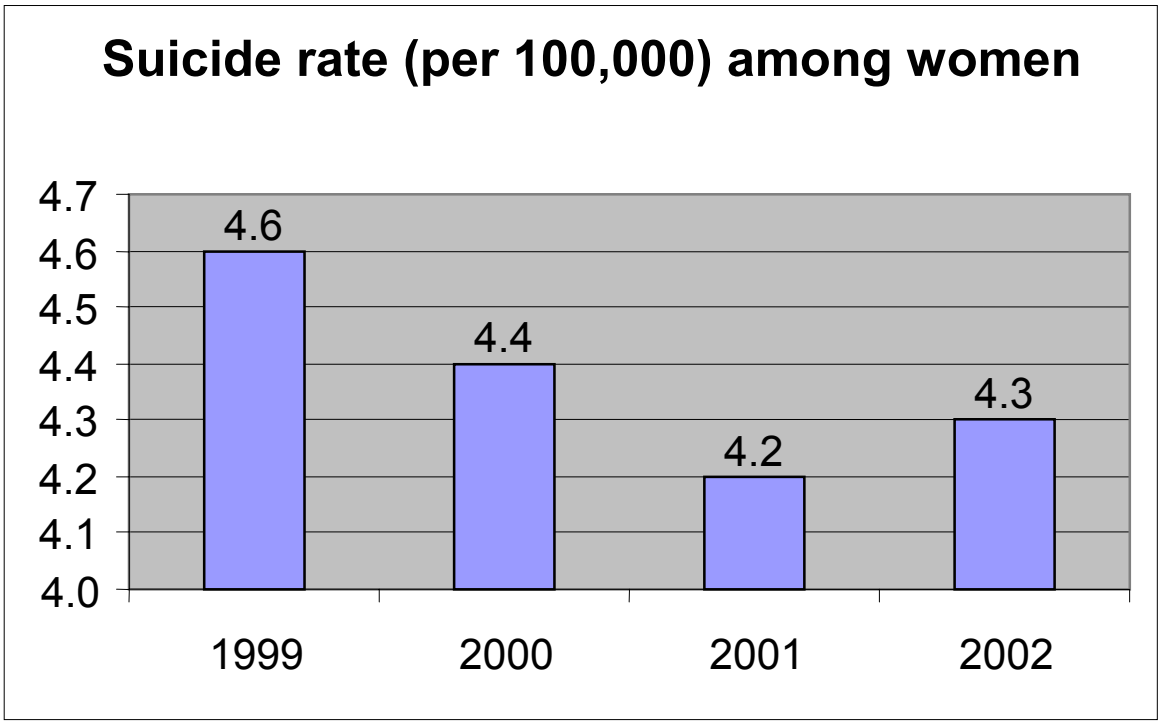
Treatment Expansion

Healthiest Wisconsin 2010 Health Priority:
Access to Primary and Preventive Health Services
Mental Health and Mental Disorders

DATA DEPICTION – Wisconsin data

Suicide rate (per 100,000) among females 18 and older[9]

	1999	2000	2001	2002
Number	125	118	116	115
Rate	4.6	4.4	4.2	4.3



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[4] The Health of Racial and Ethnic Populations in Wisconsin 1996-2000. 2004; 134. Available at: http://dhfs.wisconsin.gov/Health/MinorityHealth/Report.htm

[5] Pregnancy Risk Assessment Monitoring System (PRAMS), PRAMS and Postpartum Depression. Internet site: www.cdc.gov/reproductivehealth/srv_prams.htm. June 2004.

[6] National Women's Law Center. Making the Grade on Women's Health: A National State-by-State Report Card. University of Pennsylvania. 2001; 5:19. Available at www.nwlc.org/display.cfm?section=health

[7] The Health of Racial and Ethnic Populations in Wisconsin 1996-2000. 2004; 112. Available at: http://dhfs.wisconsin.gov/Health/MinorityHealth/Report.htm.

[8] Sample Adult Core component of the 1997-2002 National Health Interview Surveys. The estimate for 2002 was based on data collected from January through September.

[9] Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Smoking among pregnant women

DEFINITION

Percent of women who reported smoking during pregnancy.

DESCRIPTION OF THE NEED

Overall in 2003, 9,769 or 14% of pregnant women in Wisconsin reported smoking during pregnancy.[1] Although there is a downward trend since 1999, Wisconsin has a higher percentage of pregnant women who reported smoking than those reported nationally. In 2003, the proportion of mothers smoking during pregnancy in the United States decreased to 11.0%.[2] In terms of racial differences, Native American women continue to report the highest percentage of smoking during pregnancy, nearly 3 times as high as the overall state percentage.

SERIOUSNESS OF THE PROBLEM

It is well documented in the literature that smoking during pregnancy is harmful to the fetus. Smoking can cause complications during pregnancy such as miscarriage, stillbirth, impaired placental function, intrauterine growth retardation and pre-term delivery.[3] One of the most documented consequences of smoking during pregnancy is low birth weight and the need for neonatal intensive care.[4] Sudden Infant Death (SIDS) is 2 to 4 times more common in infants whose mothers smoked during pregnancy than in other babies.[3]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Prenatal Substance Exposure

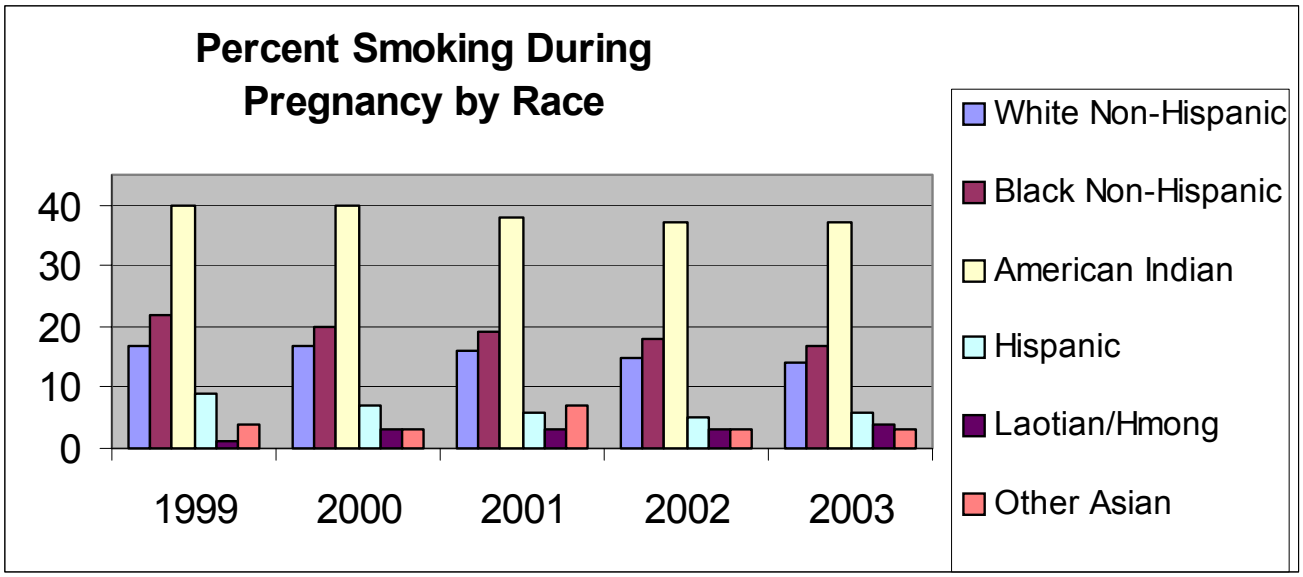
Title V State Performance Measure:

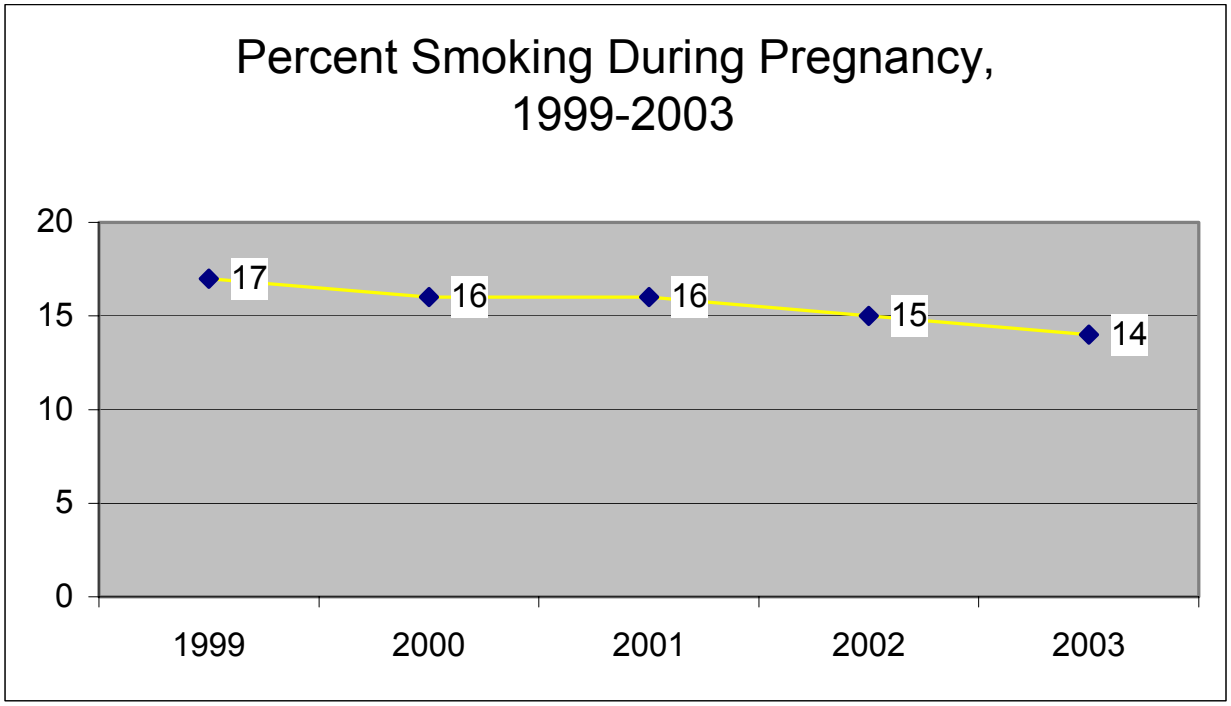
Percent of women who used tobacco during pregnancy

DATA DEPICTION

Percent of Smoking During Pregnancy By Race

Wisconsin	1999	2000	2001	2002	2003
White	17%	17%	16%	15%	14%
Black	22%	20%	19%	18%	17%
American Indian	40%	40%	38%	37%	37%
Hispanic	9%	7%	6%	5%	6%
Laotian/Hmong	1%	3%	3%	3%	4%
Other Asian	4%	3%	7%	3%	3%
All Pregnant Women Who Smoked During Pregnancy	17%	16%	16%	15%	14%





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[3] What every woman needs to know about cigarette smoking. Women's Health in Primary Care 1998: 1; 95-96.

[4] Shiono PH, Behrman RD. Low birth weight: Analysis and Recommendations. The Future of Children 1995;5(1): 4-18.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Unintended pregnancy

DEFINITION

Percent of women at risk of unintended pregnancies receiving family planning and related reproductive health services through publicly funded clinics. Unintended pregnancies are those reported to "have been either unwanted (i.e., occurring when no children, or no more children, were desired), or mistimed (i.e., occurring earlier than desired)."[1]

DESCRIPTION OF THE NEED

In 2002, Medicaid was the source of payment for 8,433 births in Milwaukee County: 57.3% of all Milwaukee County births compared to 28% of all births statewide.[2] Unintended pregnancy or unplanned birth is higher among women under age 18 (88%), and ages 20-24 (57%).[3] The City of Milwaukee had 2,021 teen births in 2002: 18.7% of all Milwaukee City births compared to 9.5% statewide (6,534). City of Milwaukee teens were 31% of all births to teens in Wisconsin in 2002.[4]

SERIOUSNES OF THE PROBLEM

Almost half (49.2%) of all pregnancies in the United States are unintended.[1] Unintended pregnancy is highest among younger women (78% ages 15-19; 58.5% ages 20-24; 39.7% ages 25-29), and among lower income women (61.4% <100% federal poverty level (FPL); 53.2% 100-199% FPL).[3]

The Institute of Medicine's report, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, thoroughly documents the scope and consequences of unintended pregnancy. Access to and effective use of contraception are two core issues related to unintended pregnancy. Unintended pregnancy among women *using* contraception is significantly less (7.08 %) compared to unintended pregnancy among women *not using* contraception (43.59 %). This means that the likelihood of unintended pregnancy among using contraception is 1 in 14; the likelihood of unintended pregnancy among sexually active women not using contraception is 1 in 2.[5]

Unintended pregnancy has significant social and economic consequences for communities, individuals, and families. Women and families who experience the highest proportion of unintended pregnancy are also the most vulnerable to its consequences. These include insufficient participation in prenatal care, and increased risks such as smoking and drinking during pregnancy, which lead to low birth weight babies, higher infant mortality, and poor child development and health.[5]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:
Family Planning

Healthiest Wisconsin 2010 Health Priority:
High-risk sexual behavior

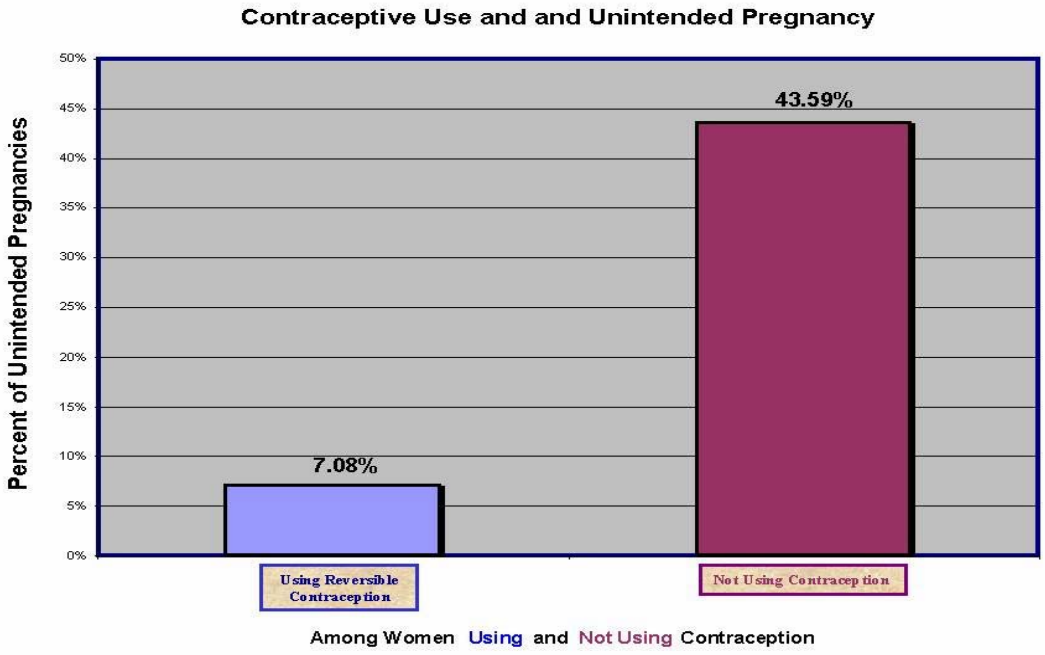
Title V State Performance Measure:
Percent of women at risk of unintended pregnancies receiving family planning ad related reproductive health services through publicly funded clinics

DATA DEPICTION –– Wisconsin data[6]

Percent of women at risk of unintended pregnancies receiving family planning and related reproductive health services through public funded clinics.[6]

Year	1998	1999	2000	2001	2002	2003
Percent	20.6%	19.3%	16.3%	18.1%	24.3%	42.9%

Contraception and Unintended Pregnancy		
Sexually Active Women	Unintended Pregnancy	
Contraceptive Status	Percent	Likelihood
Using Reversible Contraception	7.08%	1 in 14
Not Using Contraception	43.59%	1 in 2



Source: Figure 4-1 Contraceptive Status of Women Experiencing Unintended Pregnancies. *The Best of Intentions: Unintended Pregnancy and the Well-eing of Children and Families*. Institute of Medicine. 1995

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[3] Unintended Pregnancy in the United States. Stanley Henshaw. Family Planning Perspectives. Family Planning Perspectives, 1998, 30(1):24-29 & 46. http://www.agi-usa.org/pubs/journals/3002498.html

[4] Births To Teens In Wisconsin: 2002. November 2003. Wisconsin DHFS.

[5] Contraceptive Status of Women Experiencing Unintended Pregnancies. *The Best of Intentions: Unintended Pregnancy and the Well-being of Children and Families.* Institute of Medicine. 1995.

[6] Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Family and Community Health, Maternal and Child Health Title V Block Grant Application, 2004.

Enhanced *(03/25/05)*

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Teen births

DEFINITION

There are several ways to measure teen births. We are using age-specific birth rates (per 1,000 teen births) for teens less than age 18 and teens less than age 20 (available by race/ethnicity). Teen births as a percent of all births, by race/ethnicity are also given.

DESCRIPTION OF THE NEED

Teen birth rates have decreased in Wisconsin. In 1998, the birth rate for teens (<18 years) was 20.5; in 2003, 1,946 Wisconsin teens (<18 years) gave birth at a rate of 15.5 per 1,000.[1] In 2003, for teens <20 years, there were 6,317 births (rate of 32.5 per 1,000); by race/ethnic groups, there are disparities with Hispanic teens at the highest rate at 104.9, followed by Black teens (99.9), American Indian teens (76.2), and White teens (20.3).[1]

In 2003, as a percentage of all births, 9% were to teens; 24% of Black births to teens, 21% of Laotian/Hmong births to teens, 19% of American Indian births to teens, 16% of Hispanic births to teens, and 6% of White births to teens.[1]

SERIOUSNESS OF THE PROBLEM

In 2002, Wisconsin's teen birth rate (15-19) was 32.3 per 1,000 live births and one of ten states with the lowest rates.[2] Of the 50 largest US cities, Milwaukee had the second highest percent of total births to teens with 2,021 births; these Milwaukee teen births represented 31% of the teen births statewide.[3,4]

There are many social and economic consequences of adolescents having children. Teen parenthood is associated with poverty, abuse, alcohol and drug use, domestic violence, mental health issues, and school failure. Some estimates of the economic cost of teens having babies are: $1 billion for increased incarceration costs, $1.2 billion for loss tax revenue and $.08 billion for increased costs. Teen parents are less likely to complete high school and are more likely to become dependent on public assistance programs than their peers who graduate from high school. There are health consequences as well for teen parents: young female teen bodies are not completely developed and at risk of prolonged or obstructed labor.[5] Additionally, the infant mortality rate for infants born to teens is higher than for infants born to older moms, and the risk of an infant dying during its first year increases with lower educational levels, for example, less than a high school education.[6] Teen moms are more likely to have lower birth weight infants than older moms, and their infants are at greater risk for abuse and neglect. Children of teen moms are more likely to become teen moms themselves.[7]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:
Family Planning

Healthiest Wisconsin 2010 Health Priority:
High Risk Sexual Behavior

Title V National Performance Measure:
Birth rate (per 1,000) for teenagers aged 15 through 17 years

DATA DEPICTION – Wisconsin data[1]

Wisconsin: Birth rate (per 1,000) for teens, <18 years[1]

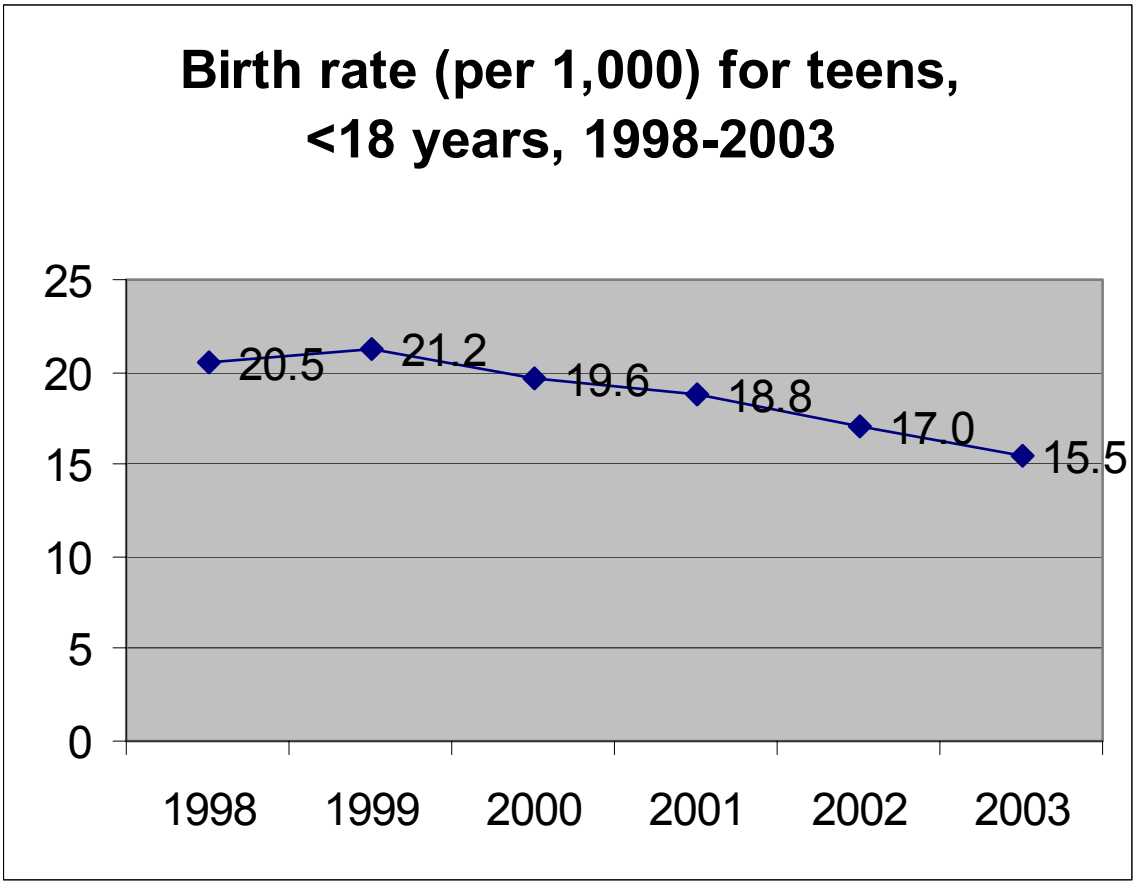
1998	1999	2000	2001	2002	2003
20.5	21.2	19.6	18.8	17.0	15.5

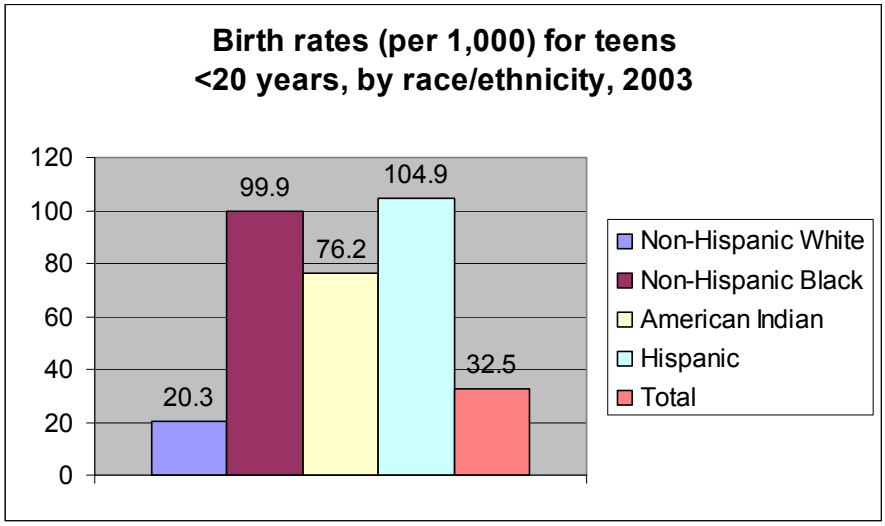
Wisconsin: Birth rates per 1,000 for teens <20 years, by race/ethnicity, 2003[1]

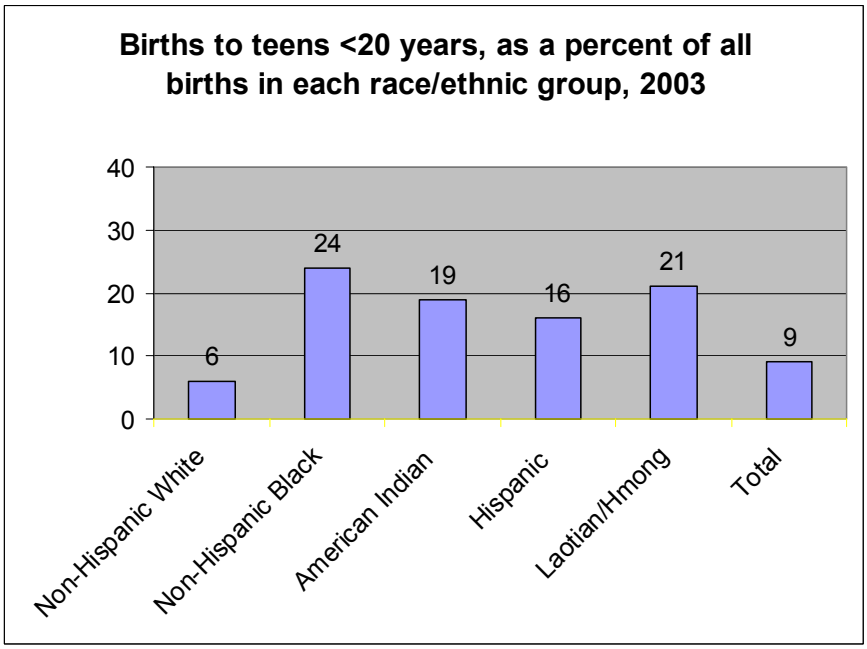
Race / Ethnicity	Rate/1,000
Non-Hispanic White	20.3
Non-Hispanic Black	99.9
American Indian	76.2
Hispanic	104.9
Total	32.5

Wisconsin: Births to teens <20 years, as a percent of all births in each race/ethnic groups, 2003[1]

Race / Ethnicity	Percent
Non-Hispanic White	6%
Non-Hispanic Black	24%
American Indian	19%
Hispanic	16%
Laotian/Hmong	21%
Total	9%







DATA SOURCE

[1] Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy. ***Births to Teens in Wisconsin, 2003*** (PPH 5365-03). October 2004.
[2] Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Munson ML. Births: Final data for 2002. National vital statistics reports: vol 52 no 10. Hyattsville, Maryland: National Center for Health Statistics, 2003.
[3] Anne E. Casey Foundation. Kids Count, Right State Online 2005. Profile of Milwaukee, WI. Available at; http://www.aecf.org/cgi-bin/rs.cgi?action=profile&area=Milwaukee%2c+WI, accessed 03/07/05. [
[4] Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information. ***Births to Teens in Wisconsin, 2002*** (PHC 5365). November, 2003.
[5] Alan Guttmacher Institute. *Risks and Realities of Early Childbearing Worldwide.* Washington, DC, 1997.
[6] Mathews TJ, Curtin SC, MacDorman MF. Infant mortality statistics from the 1998 period linked birth/infant death data set. *National Vital Statistics Reports,* vol 48 (12). Hyattsville, MD: National Center for Health Statistics, 2000. https://www.cdc.gov/nchs/data/nsvsr/nvsr48/nvsr48_12.pdf.
[7] Maynard, RA. Ed. *Kids Having Kids: A Robin Hood Foundation Special Report on the Costs of Adolescent Childbearing.* New York: Robin Hood Foundation, 1996.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

HIV/AIDS

DEFINITION

HIV infection case, rate per 100,000.

DESCRIPTION OF THE NEED

In 2003, Wisconsin's reported AIDS case rate was 6.6.[1] In Wisconsin, in 2002, 84% of reported HIV infections were reported among males, compared to 16% among women.[1] By exposure category, the highest proportion of HIV cases were among men who have sex with men (52%), followed by injection drug users (15%), and heterosexual contact (12%). One percent of HIV cases were infants born to mothers with HIV infection. However, Wisconsin's minority populations are disproportionately affected by HIV infection. From 1996-2000, over 50% of all reported HIV infections occurred in members of racial or minority groups. The proportion of deaths that occurred in racial and mintority populations was 44%, including African American 34%, and Hispanic/Latino 8%.[2]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

HIV/AIDS

Healthiest Wisconsin 2010 Health Priority:

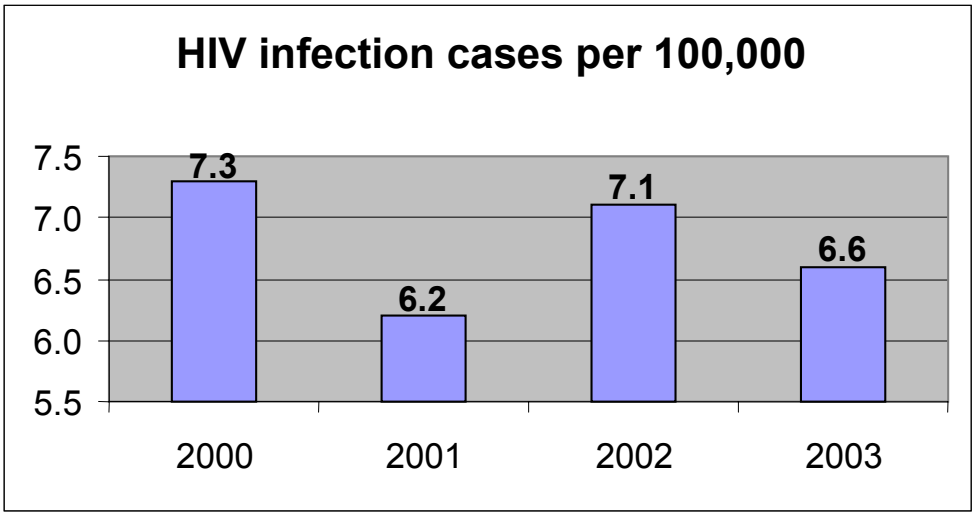
High Risk Sexual Behavior

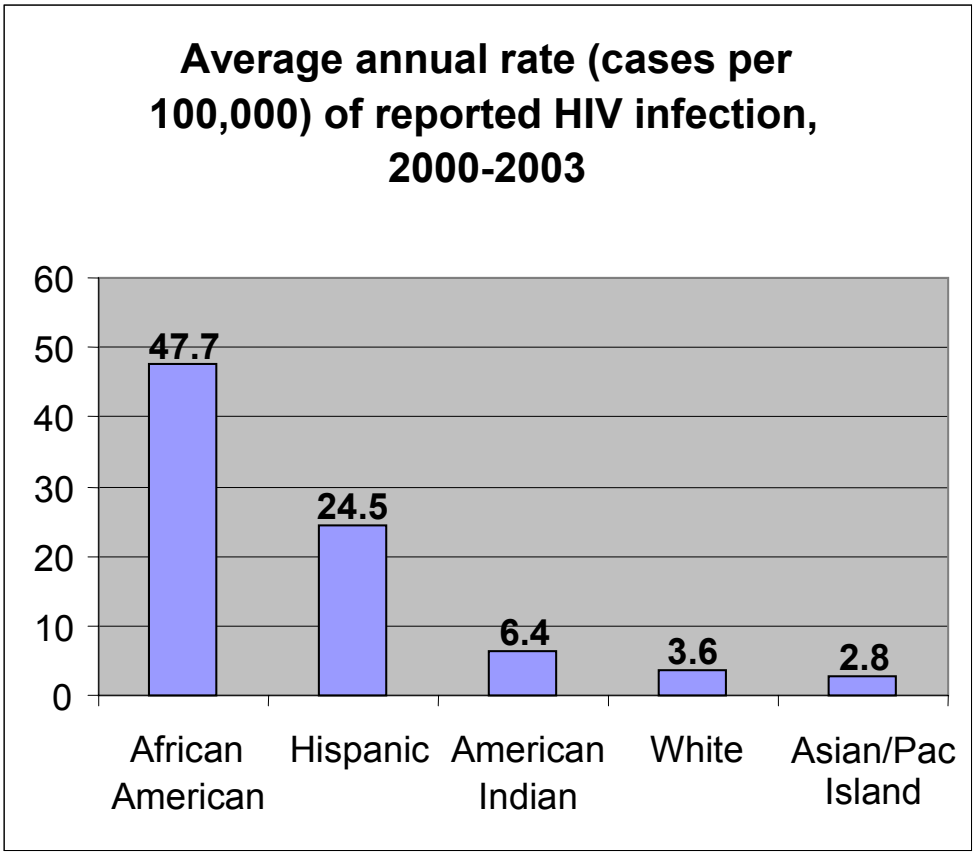
DATA DEPICTION

HIV infection reported cases (rate per 100,000)[2]

Year	Rate
2000	7.3
2001	6.2
2002	7.1
2003	6.6

Race/Ethnicity	Rate
African American	47.7
Hispanic	24.5
American Indian	6.4
White	3.6
Asian/Pac Islander	2.8





DATA SOURCE

[1] Wisconsin Department of Health and Family Services, Divison of Public Health, Bureau of Communicable Diseases and Preparedness, AID/HIV Program, Wisconsin AIDS/HIV Surveillance Data Update, Cases and deaths reported through December 31, 2003.

[2] Wisconsin Department of Health and Family Services, Divison of Public Health, Minority Health Program. The Health of Racial and Ethnic Populations in Wisconsin: 1996-2000 (PPH 0281 07/04). Madison, Wisconsin Department of Health and Family Services.

(11/05/04)

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

STIs, Chlamydia, and Gonorrhea

DEFINITION

Reported cases (morbidity) to the Sexually Transmitted Disease Program, Bureau of Communicable Diseases and Preparedness, Division of Public Health, Wisconsin Department of Health and Family Services.

DESCRIPTION OF THE NEED

Sexually transmitted infections (STIs) including Chlamydia and Gonorhea represent the largest group of communicable diseases reported in Wisconsin-larger than all other reported communicable disease combined. There are significant health, financial, and emotional consequences from STIs: infertility, ectopic pregnancy, reproductive cancer, higher costs of health care, loss of employment and work time, stress on relationships, and grief over fertility loss. In Wisconsin, STIs occur predominately among teenagers and young adults. In 2003, there were 17,769 reported cases of chlaymida infections, with 3 out of 4 cases reported for women (men are under represented in reported chlamydia data because of lack of access for testing), about 75% of these cases were in the age group of 15-24 years. Reported prevalence of gonorrhea and chlamydia is consistently higher among minorities, most notably among African Americans.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Bacterial STD Illness and Disability
Personal Behaviors

Healthiest Wisconsin 2010 Health Priority:

High Risk Sexual Behavior

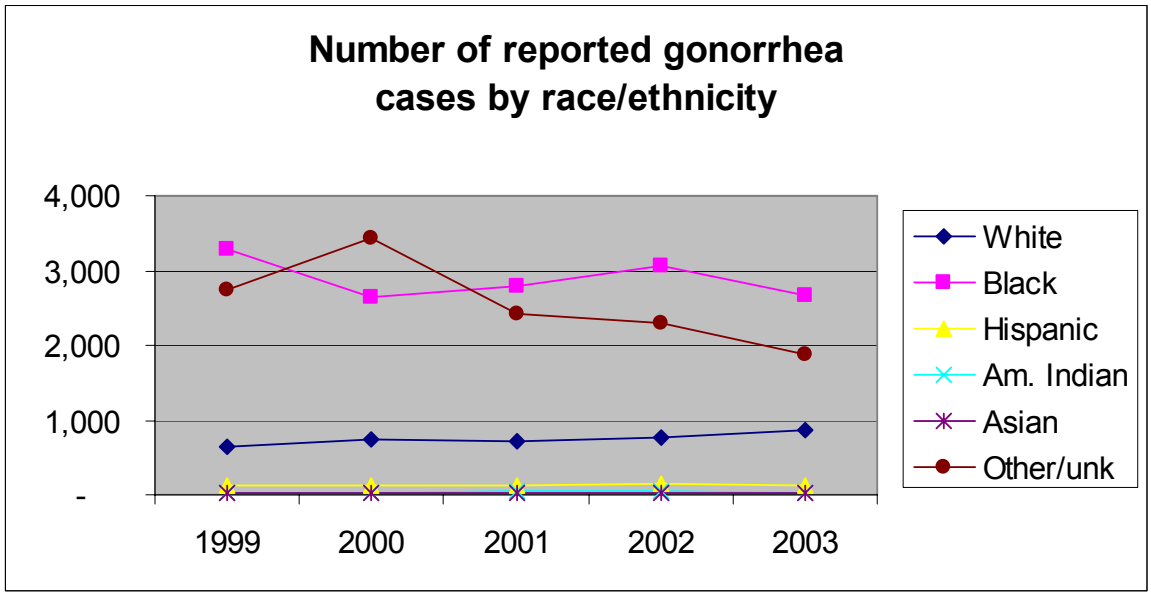
DATA DEPICTION

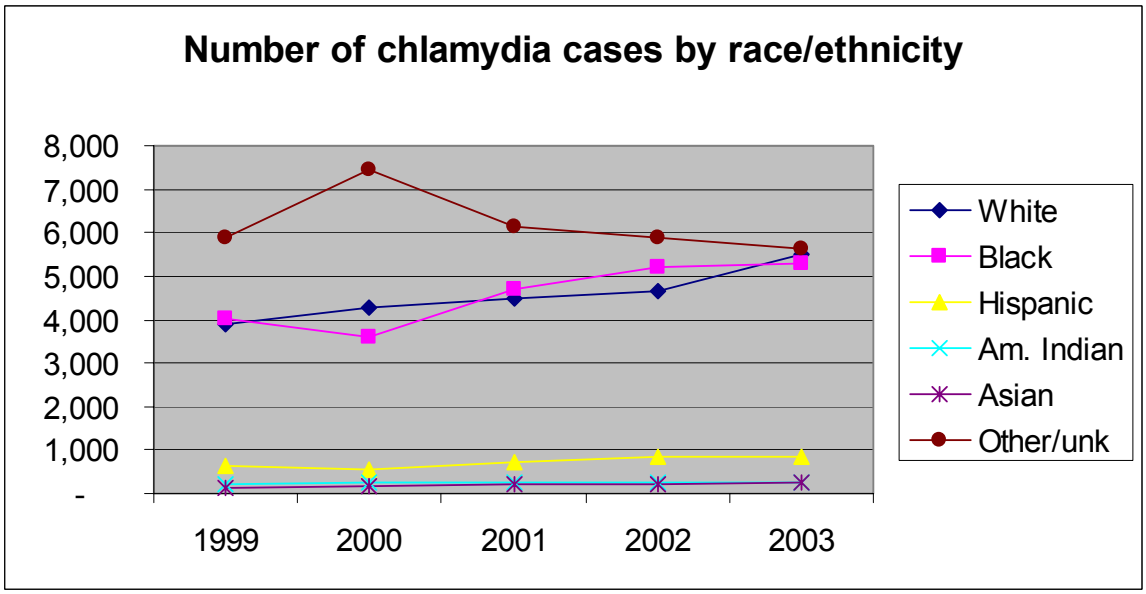
Number of reported Gonorrhea cases by Race 1999-2003

	1999	2000	2001	2002	2003
White	644	734	716	777	862
Black	3,293	2,644	2,783	3,057	2,668
Hispanic	125	128	119	145	117
Am. Indian	36	26	38	60	37
Asian	20	19	31	30	27
Other/Unk	2,744	3,438	2,428	2,293	1,887
Total	6,862	6,989	6,115	6,362	5,596

Number of reported Chlamydia cases by Race 1999-2003

	1999	2000	2001	2002	2003
White	3,902	4,266	4,493	4,652	5,505
Black	4,004	3,605	4,710	5,199	5,294
Hispanic	621	559	714	839	833
Am. Indian	215	261	266	273	246
Asian	127	156	214	216	251
Other/Unk	5,890	7,470	6,156	5,879	5,640
Total	6,853	8,446	7,350	7,207	6,970





DATA SOURCE

Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Communicable Diseases and Preparedness, Sexually Transmitted Diseases Program, 2004.

(11/05/04)

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Contraceptive services

DEFINITION

Number of women in need of publicly- supported contraceptive services and supplies, by race/ ethnicity, and age (15-55), and poverty (under 250%).

DESCRIPTION OF THE NEED

Women are defined as "in need of contraceptive services and supplies" during a given year if they are ages 13-44 and meet three criteria: 1) they are sexually active, that is, they have ever had intercourse; 2) they are fecund, meaning that neither they nor their partner have been contraceptively sterilized, and they do not believe that they are infecund for any other reason; and 3) during at least part of the year, they are neither intentionally pregnant nor trying to become pregnant.[1]

Women are defined as "in need of publicly-funded contraceptive services and supplies" if they meet the above criteria and have a family income under 250% of the federal poverty level (estimated to be less than $42,625 for a family of four). All women younger than 20 who need contraceptive services and supplies are assumed to need publicly supported care, either because their personal incomes are below 250% of poverty or because of their heightened need—to preserve confidentiality—for obtaining care that does not depend on their family's resources or private insurance.

640,420 women ages 13-44 are estimated to be in need of contraceptive services and supplies in Wisconsin.[1] Ninety-three percent of females aged 15 to 44 years at risk of unintended pregnancy used contraception in 1995.[2] (*References Graph* 1)

Approximately 17% of the estimated need for public supported family planning services has been met through the Medicaid Family Planning Waiver through December 31, 2004.[3] (*References Graph* 2)

SERIOUSNESS OF THE PROBLEM

More than half of all unintended pregnancies are ended with abortion. Access to and use of contraception can significantly prevent the circumstances in which abortion may be considered as an option. One contraceptive method alone, emergency contraception, could prevent most abortions. Among women having unintended pregnancy, approximately 93% of abortions could be prevented through the use of emergency contraception. Approximately 55% of unintended pregnancies are ended with abortion. Therefore, among 80 unintended pregnancies, 44 abortions would be expected *without* the use of emergency contraception compared to 3 with early use of emergency contraception. Thus, prevention of 41 abortions (44 to 3) would be a 93% reduction. (*References Graph* 3)

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Family Planning

Healthiest Wisconsin 2010 Health Priority:

High-risk sexual behavior

(1)

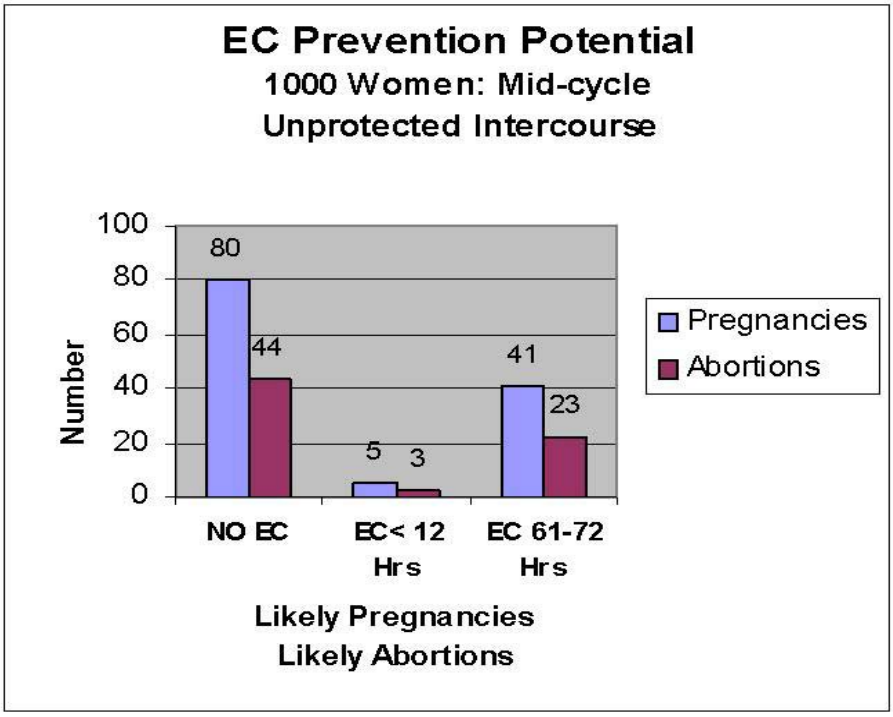
Wisconsin Women in Need of Contraceptive Services and Supplies, 2002									
All Women	Needing Services & Supplies					Women 20-44			Women
13-44	Ages					Poverty			<20 &
All Ages	<18	18-19	20-29	30-44	Total	<100%	100%-184%	185%-249%	20-44 <185%
1,239,480	42,100	53,220	276,110	268,990	640,420	67,230	72,740	65,240	235,290

Source: AGI -Women in Need of Contraceptive Services and Supplies, 2002
http://www.guttmacher.org/pubs/win/states/wisconsin.pdf

(2)

Wisconsin Medicaid Family Planning Waiver				
Estimates of Income Eligible Women		Enrollees	Percent of Estimates Enrolled as of 12/31/2004	
Column 1	Column 2	Column 3	Column 3/1	Column 3/2
Estimated Income Eligible Population	AGI Contraceptive Need, 2000 Ages <20 & 20-44 <185%	Medicaid Waiver Enrollees Through 12/31/2004	Enrollees as a Percent of Estimated Income Eligible Women	Enrollees as a Percent of AGI Contraceptive Need Estimates
320,422	230,060	55,515	17.33%	24.13%

(3)



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[1] The Alan Guttmacher Institute: Contraceptive Needs and Services, 2001-2002

[2] National Survey of Family Growth (NSFG), CDC, NCHS

[3] Medicaid Family Planning Enrollment data: 12/31/2004

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Folic acid knowledge and use

DEFINITION

Percent of women who have knowledge of the folic acid benefit and their use of folic acid.

Folic acid, also known as folate, is a B-vitamin that can be found in some enriched foods and vitamin pills. On the Wisconsin Behavioral Risk Factor Survey Folic Acid Module, folic acid use is derived from women who responded *yes* to "Do any of the vitamin pills or supplements you take contain folic acid?" Women who said they are taking vitamins but didn't know if the vitamin contained folic acid were not counted as taking folic acid. Folic acid knowledge is derived from women who correctly answered the question: "Some health experts recommend that women take 400 micrograms of the B vitamin folic acid, for which of the following reasons….?" The correct response is: "To prevent birth defects."

DESCRIPTION OF THE NEED

Neural tube defects, birth defects of the brain and spine resulting from failure of the neural tube to close normally between the third and fourth week of embryological-development, are among the most common birth defects contributing to infant mortality and serious disability. Neural tube defects occur in approximately 1 in 1,000 births. Research has shown that folic acid consumption, before pregnancy and during the first few weeks of pregnancy, can reduce the incidence of children born with neural tube defects by greater than 50%. The U.S. Public Health Service recommends that all women of childbearing age who are capable of becoming pregnant consume 400 mcg (0.4 mg) of folic acid per day, including women who are not actively planning a pregnancy since approximately half of all pregnancies are not planned.[1]

In 2002, only 20.5% of Wisconsin women responding to the Wisconsin Behavioral Risk Factor Survey correctly identified birth defect prevention as the reason for the recommendation to take 400 mcg of folic acid daily, and only 3.1% reported that they take a vitamin pill or supplement containing folic acid. In 2002, among pregnant women, 77.4% had knowledge of the benefit for folic acid, and 7% reported use of vitamin pills or supplements containing folic acid. Because the evidence regarding the benefits of folic acid is strong, it is critical that women of childbearing age in Wisconsin understand the link between folic acid and the prevention of neural tube defects, and are encouraged to consume the recommended amount of folic acid on a daily basis.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Risk Factors

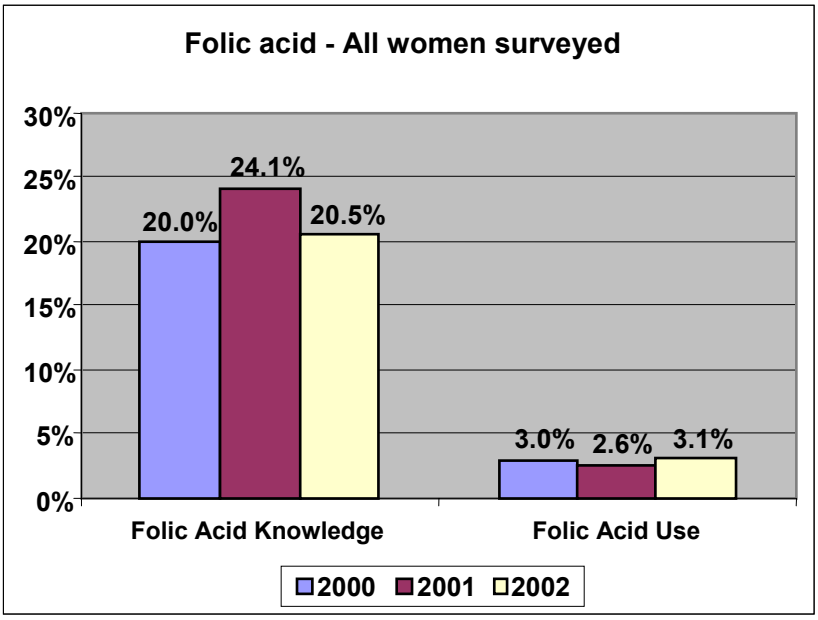
Healthiest Wisconsin 2010 Health Priority:

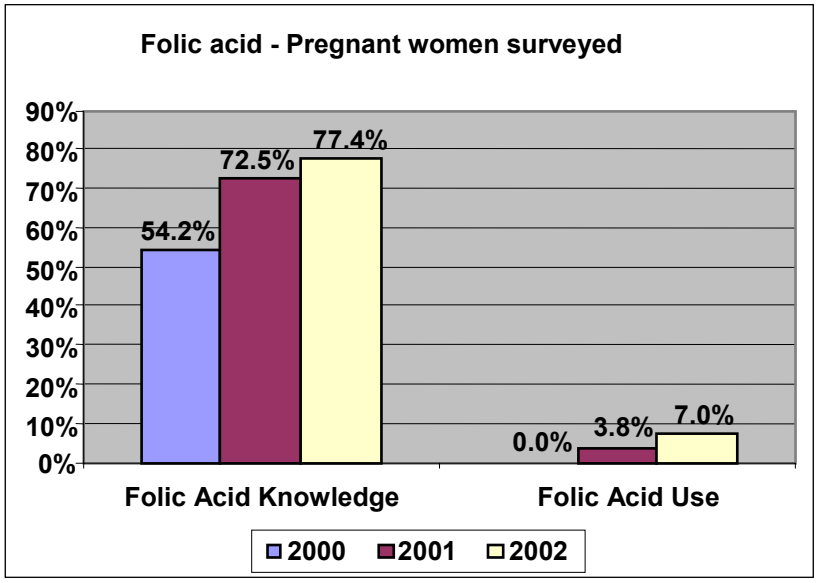
Adequate and appropriate nutrition

DATA DEPICTION[2]

Percent of women who have knowledge of the folic acid benefit and use of folic acid.

	2000	2001	2002
Folic acid knowledge (prevents birth defects)	20.0%	24.1%	20.5%
Folic acid use	3.0%	2.6%	3.1%





DATA SOURCE

[1] 1999 Position Statement: Folic Acid for the Prevention of Neural Tube Defects. *Pediatrics*. 1999; 104(2); 325-327.

[2] Data derived from the Behavioral Risk Factor Survey (BRFS) conducted annually in Wisconsin. The folic acid questions are a separate add-on module that was used in Wisconsin in 2000, 2001, and 2002. Percents are weighted.

(11/05/04)

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Intentional childhood injuries

DEFINITION

Number of intentional injury deaths and number of intentional injury hospitalizations.
Injury is defined as "any damage to the body resulting from acute exposure to thermal, mechanical, electrical or chemical energy or from the absence of such essentials as heat or oxygen."[1] Intentional injury is caused by a purposeful human action. Intentionality usually refers to some type of violence, either self-inflicted or inflicted by another. It is important to note that it may be difficult to determine intent. Almost any type of injury can be caused by a willful act, but certain types of injuries usually fit more appropriately into one category versus the other.[2] "Childhood" refers to children, teenagers, and young adults aged 0-21.

DESCRIPTION OF THE NEED

Injury is a major cause of premature death and disability among children, teenagers, and young adults. More than 2,100 children, teenagers, and young adults up to 21 years of age died from injuries (unintentional and intentional) and more than 37,300 were hospitalized between 1998-2002.[3] Of these more than 2,100 deaths of Wisconsin children, teenagers, and young adults, 342 were murdered and 354 were suicides.

SERIOUSNESS OF THE PROBLEM

The number of suicide and assault deaths in Wisconsin for the 0-21 age group both increased in 2003, and the primary mechanism used in these deaths was a firearm, particularly in the age group 15-21 (64%).[3] In 2003, the estimated Years of Potential Life Lost (YPLL) in Wisconsin due to suicide in the 0-21 age group was 4,290 years, and the YPLL for assault for this same age group was 3,355 years. YPLL is a statistic that is the sum of the years of life lost annually by persons who suffered early deaths. The total hospitalization charges for intentional injuries in 2002 for ages 0-21 were $17,795,242.00 dollars.[3]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:
Injury Prevention

Healthiest Wisconsin 2010 Health Priority:
Intentional and Unintentional Injuries and Violence

Title V National Performance Measure:
Rate (per 100,000) of suicide deaths among youths aged 15-19

DATA DEPICTION – Wisconsin data[3]

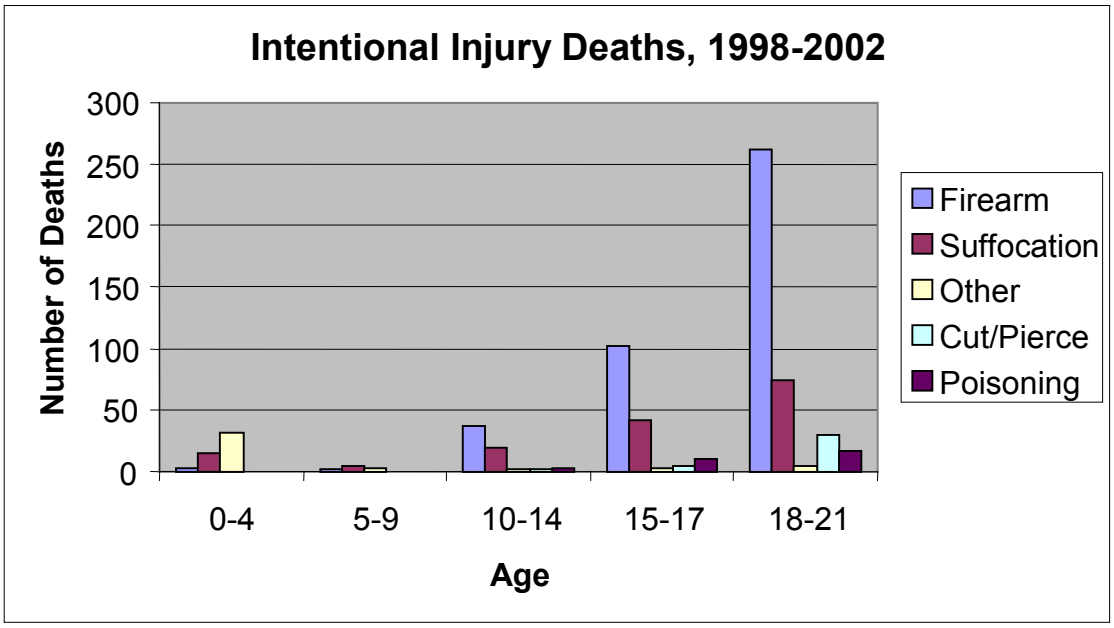
(1998-2002)

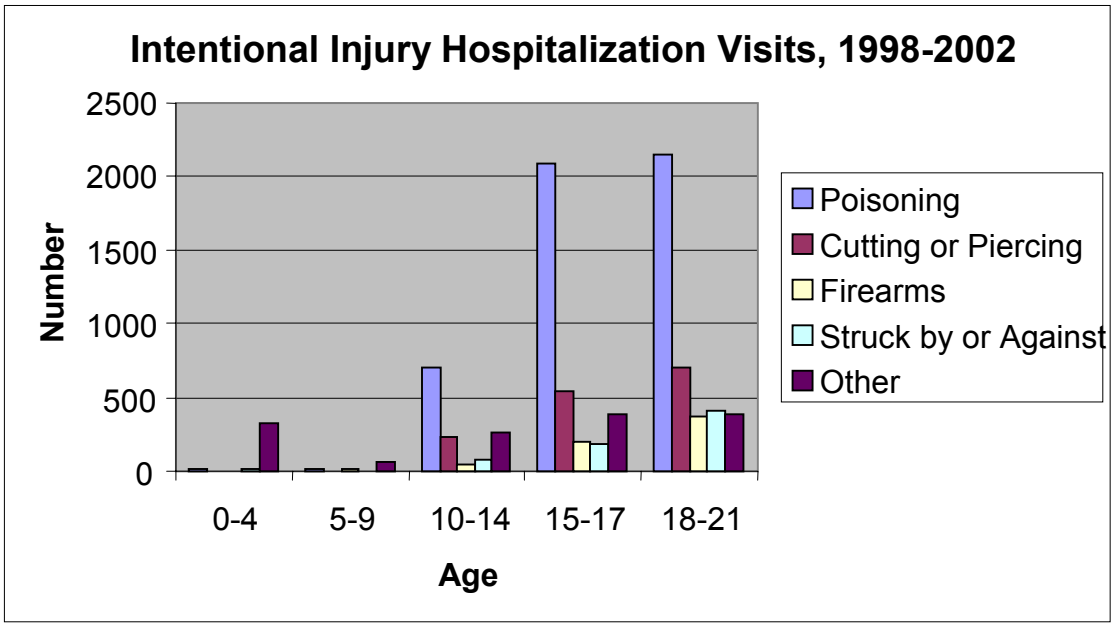
Number of Intentional Deaths by Cause

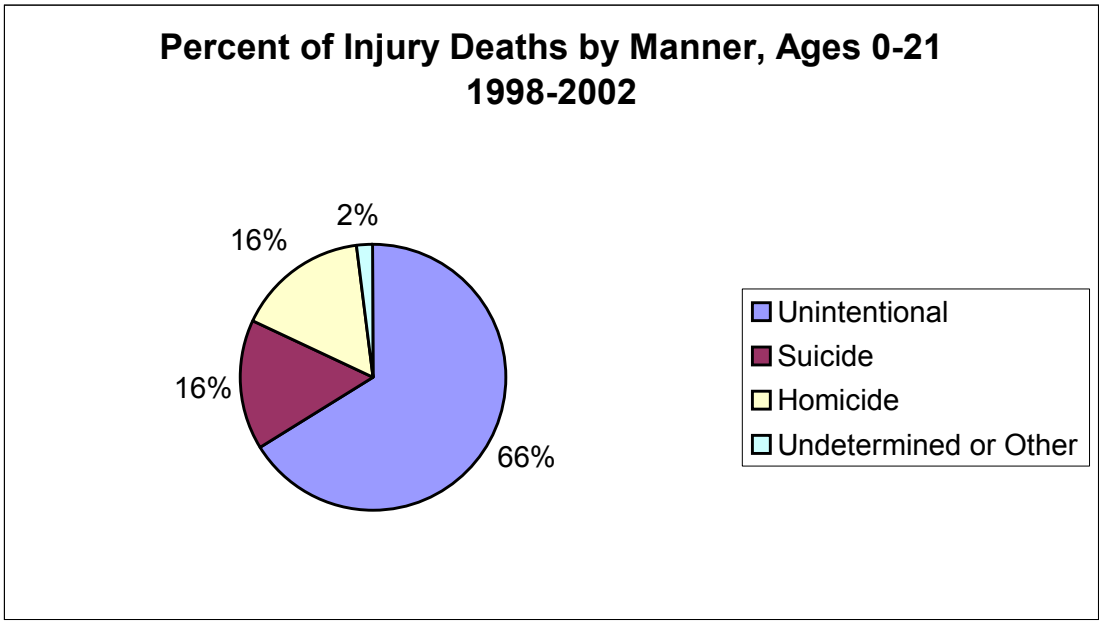
Wisconsin	0-4	5-9	10-14	15-17	18-21
Firearm	3	2	37	103	261
Suffocation	15	4	20	41	75
Other	31	3	1	3	4
Cut/Pierce	0	0	2	4	29
Poisoning	0	0	3	11	17

Number of Intentional Hospitalizations by Cause

Wisconsin	*0-4*	*5-9*	*10-14*	*15-17*	*18-21*
Poisoning	10	12	707	2,097	2,151
Cutting or Piercing	4	2	232	545	700
Firearms	1	9	50	192	366
Struck by or Against	10	6	70	185	412
Other	321	59	260	388	387







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[1] National Committee for Injury Prevention & Control, 1989

[2] NHTSA: Pier Injury Prevention Curriculum: Module I: Injury Prevention Basics, October 2002

[3] Wisconsin Interactive Statistics on Health Query System (WISH), Mortality and Injury Hospitalization Modules, 1998-2002 (http://dhfs.wisconsin.gov/wish/). Bureau of Health Care Information and Policy, Division of Public Health, Wisconsin Department of Health

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Suicide deaths

DEFINITION

Suicide is defined as purposely self-inflicted, intentional self-harm.

DESCRIPTION OF THE NEED

In 2002, there were 626 suicide deaths, 4,983 suicide related hospitalizations, and 3,771 emergency room visits related to suicide attempts. These trends continue when examining the data from 1995-2002. The largest number of deaths occur in the 35-44 age group, but the largest number of suicide-related hospitalizations occur in the 15-24 age group. There are also gender differences when comparing deaths to hospitalizations. From 1995-2002, there were 3,931 male suicide deaths, compared to 907 female deaths. In hospitalization suicide visits, there were 13,385 for males, and 23,836 for females.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Mental Health Status Improvement

Healthiest Wisconsin 2010 Health Priority:

Intentional and Unintentional Injuries and Violence

Title V National Performance Measure:

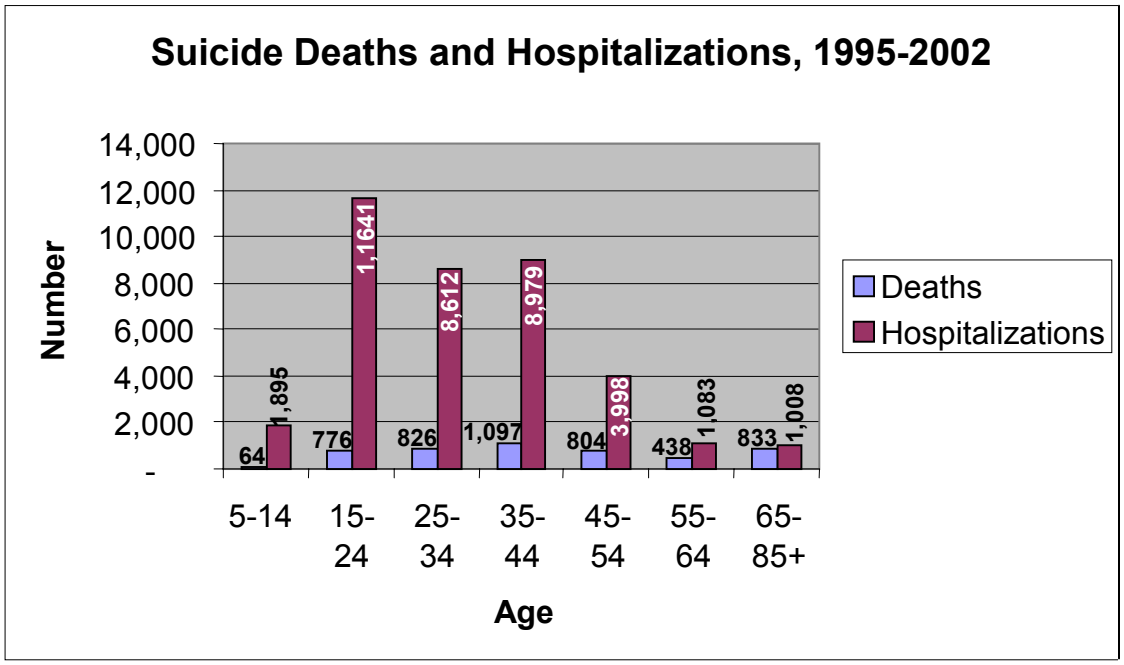
Rate (per 100,000) of suicide deaths among youths 15-19

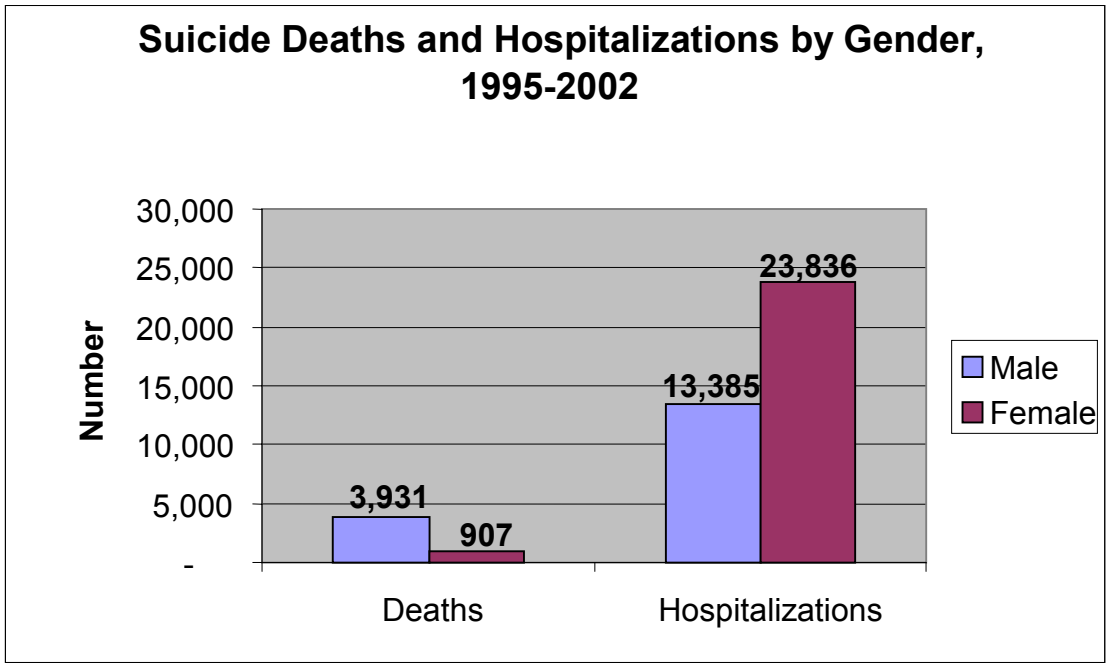
DATA DEPICTION

Number of suicide deaths and hospitalizations by age and gender

Age	Deaths	Hospitalizations
5 - 14	64	1,895
15 - 24	776	11,641
25 - 34	826	8,612
35 - 44	1,097	8,979
45 - 54	804	3,998
55 - 64	438	1,083
65 - 85+	833	1,008

	Deaths	Hospitalizations
Male	3,931	13,385
Female	907	23,836





DATA SOURCE

Wisconsin Interactive Statistics on Health Query System (WISH), Mortality and Injury Hospitalization Modules, 1995-2002 (http://dhfs.wisconsin.gov/wish/). Bureau of Health Care Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Homicide deaths

DEFINITION

Homicide is defined as injuries inflicted by another person with intent to injure or kill.

DESCRIPTION OF THE NEED

The average number of deaths due to homicide was 195 from 1999 to 2002. The age group with the highest average number of homicides was 24-44, followed by the 0-19 age group. In terms of race, the highest number of homicide deaths occurred among African Americans in the 25-44 age group, followed by 0-19. Whites in the 45-64 and 65-98 age groups have the highest number of homicide deaths.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Violence and Abuse Prevention

Healthiest Wisconsin 2010 Health Priority:

Intentional and Unintentional Injuries and Violence

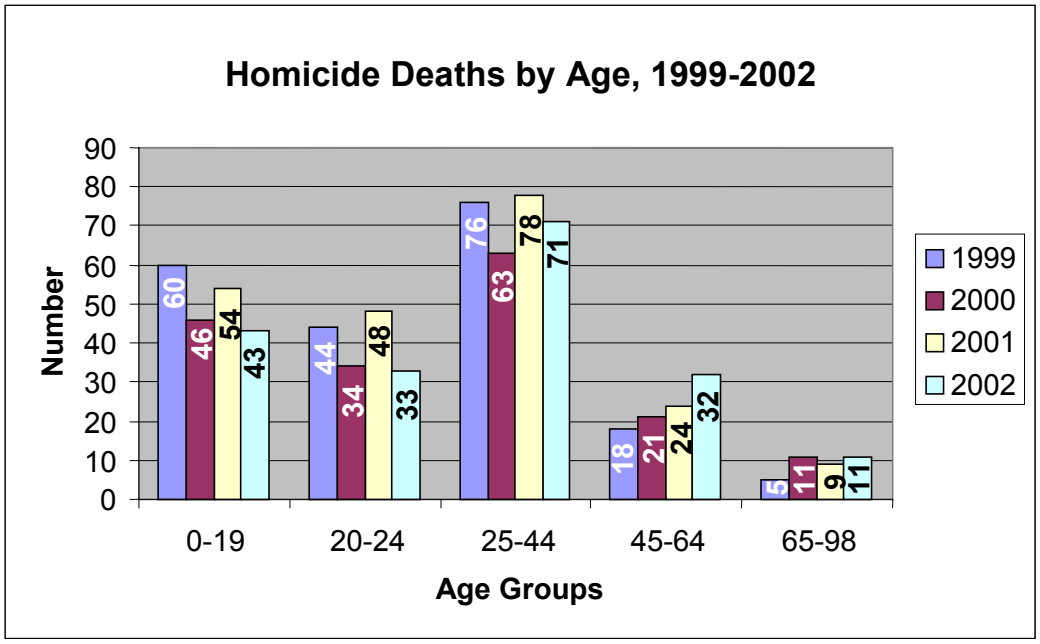
DATA DEPICTION

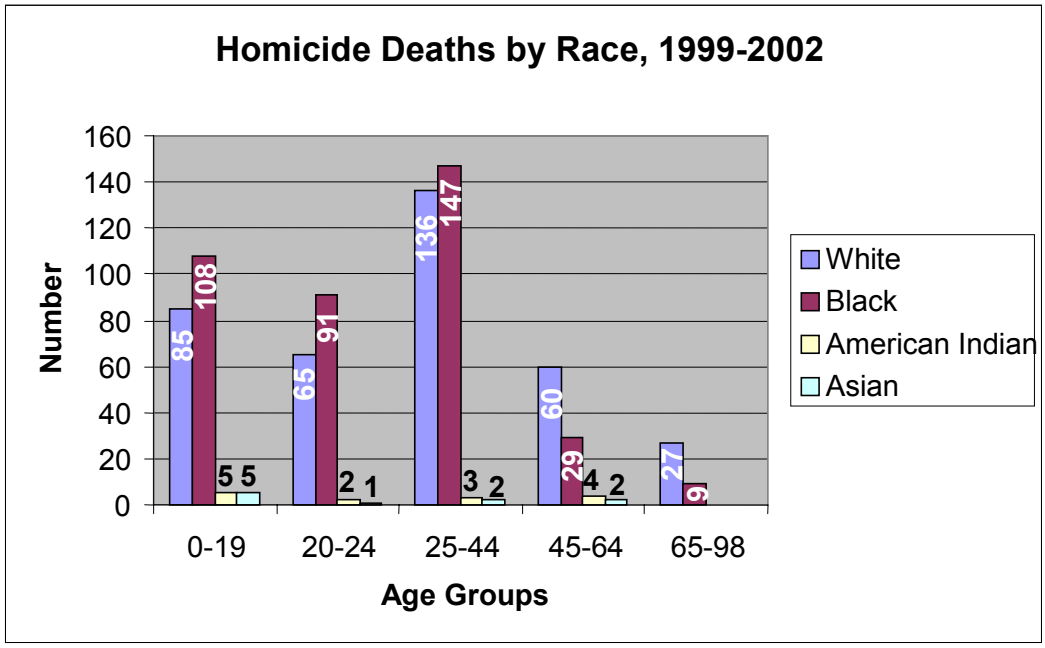
Number of Homicide Deaths by age, 1999-2002

	1999	2000	2001	2002
0 - 19	60	46	54	43
20 - 24	44	34	48	33
25 - 44	76	63	78	71
45 - 64	18	21	24	32
65 - 98	5	11	9	11

Number of Homicide Deaths by Race, 1999-2002

	White	Black	Am Indian	Asian
0 - 19	85	108	5	5
20 - 24	65	91	2	1
25 - 44	136	147	3	2
45 - 64	60	29	4	2
65 - 98	27	9	0	0





DATA SOURCE

Wisconsin Interactive Statistics on Health Query System (WISH), Injury Mortality Module, 1999-2002 (http://dhfs.wisconsin.gov/wish/). Bureau of Health Care Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services.

(11/05/04)

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Child abuse and neglect

DEFINITION

Number of substantiated child abuse and neglect reports that consist of physical abuse and neglect, sexual abuse, and emotional abuse.

DESCRIPTION OF THE NEED

In 2002, there were 42,698 total reports of child abuse and neglect with substantiations in Wisconsin.[1] These are the reports that are investigated; an unknown number of reports are screened out and not investigated and, consequently, not included in these data. The largest number of substantiated reports are for children between the ages 12 and 14. Between 2000 and 2002, there were slightly more reports and substantiations for female children than males.

SERIOUSNESS OF THE PROBLEM

According to the National Clearinghouse on Child Abuse and Neglect, children who were victims of child abuse or neglect totaled 903,000 in 2003 in the United States.[2] Sometimes the physical injuries are not immediately visible, but the consequences of abuse and neglect may last generations.

Often the impact of child abuse and neglect is discussed in terms of physical, psychological, behavioral, and societal consequences, but in reality, one can not separate them completely. Physical damage can have psychological implications. Psychological problems can often turn into high-risk behaviors. Someone who suffers from depression and anxiety might be more likely to smoke, abuse alcohol or drugs. These high-risk behaviors can then lead into long-term physical health problems such as cancer from smoking, or obesity from overeating.

Child abuse and neglect can also create societal consequences. It is estimated that nationally the direct costs associated with maintaining a child welfare system to investigate allegations of child abuse and neglect are $24 billion dollars each year (2001). The national indirect costs that represent the long-term economic consequences of child abuse and neglect are estimated to be $69 billion dollars per year (2001).

NATIONAL / STATE GOAL

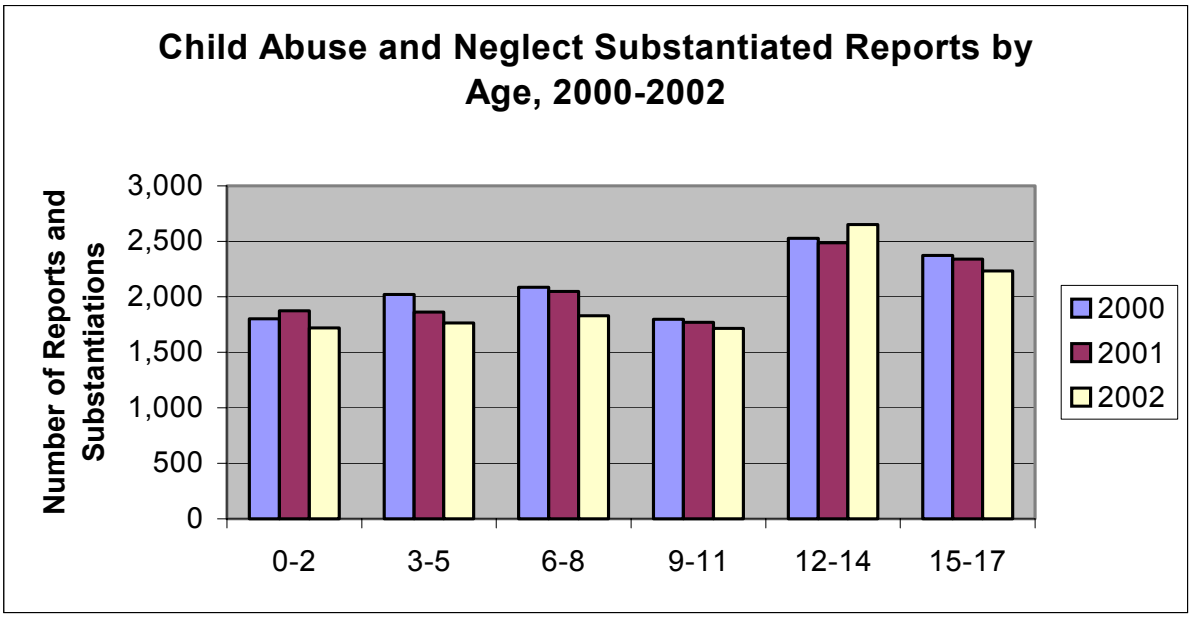
Healthy People 2010 Chapter:
Violence Abuse and Prevention

Healthiest Wisconsin 2010 Health Priority:
Intentional and Unintentional Injury and Violence

DATA DEPICTION-Wisconsin data[1]

Number of Child Abuse and Neglect Reports and Substantiation's (2000-2002)

WI Year	Total Reports	Males	Females	Abuse/Neglect found likely to occur	Maltreatment Substantiation's
2000	38,010	18,935	22,545	2,465	10,144
2001	40,215	20,045	23,222	2,589	9,795
2002	42,698	20,829	21,820	2,588	9,329



REFERENCES

[1] Annual Report to the Governor and Legislature on Wisconsin Child Abuse and Neglect, 2000, 2001, and 2002. Office of Policy, Evaluation, and Planning. Division of Children and Family Services, Department of Health and Family Services.

[2] National Clearinghouse on Child Abuse and Neglect Information. *Long-term Consequences of Child Abuse and Neglect.* 2004.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Unintentional childhood injuries

DEFINITION

Number of unintentional injury deaths and number of unintentional injury hospitalizations.
Injury is defined as "any damage to the body resulting from acute exposure to thermal, mechanical, electrical or chemical energy or from the absence of such essentials as heat or oxygen."[1]
Unintentional injury occurs with no intent to harm.[2] "Childhood" refers to children, teenagers, and young adults aged 0-21.

DESCRIPTION OF THE NEED

Injury is a major cause of premature death and disability among children, teenagers, and young adults. Among youths ages 1-19, unintentional injuries are responsible for more deaths than homicide, suicide, congential anomalies, cancer, heart disease, respiratory illness, and HIV combined (CDC). Unintentional injuries to children are costly. For every fatal injury, nationally approximately 18 children are hospitalized and 233 are treated in emergency rooms for nonfatal injuries. Most unintentional injury deaths to children can be prevented, e.g., child car seats, bicycle helmets and other protective gear, smoke detectors in homes, and controlling traffic in residential neighborhoods. In Wisconsin there are almost two times the number of unintentional injuries and deaths than intentional or violent injuries and deaths in this age group (0-21). More than 2,100 children, teenagers, and young adults up to 21 years of age died from injuries and more than 37,300 were hospitalized between 1998-2002.[3] Of these deaths, 916 died from injuries related to motor vehicles. Injuries such as drownings and fires accounted for more than 300 unintentional injury deaths. The leading injury hospitalizations for ages 0-21 were motor vehicle related and fall injuries totaling 4,054 out of the more than 37,300 hospitalizations.

SERIOUSNESS OF THE PROBLEM

Nationally, the number of Unintentional Injury Deaths for the 0-21 age group is on the rise, from 15,666 in 2001, to 16,080 in 2002.[3] This trend is also being seen in Wisconsin. In 2001, the number of Unintentional Injury Deaths for the 0-21 age group was 256, and in 2003, the number increased to 310. The Years of Potential Life Lost (YPLL-65) for Unintentional Injury Deaths for 0-21 was 17,050 in 2003. YPLL is a statistic that is the sum of the years of life lost annually by persons who suffered early deaths. In 2002, the total Wisconsin hospitalization charges for unintentional injuries for individuals 0-21 ages were $85,950,455.00 dollars.[3]

In Wisconsin during 2003, 19 children 14 years and younger died as occupants in motor vehicle crashes. In 2002, 139 were admitted to the hospital and 3,566 visited the emergency room. In the 15-21 age group, 147 died as motor vehicle occupants, 781 were admitted to the hospital, and 10,398 were seen the emergency room.[3]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:
Unintentional Injury Prevention

Healthiest Wisconsin 2010 Health Priority:
Intentional and Unintentional Injuries and Violence

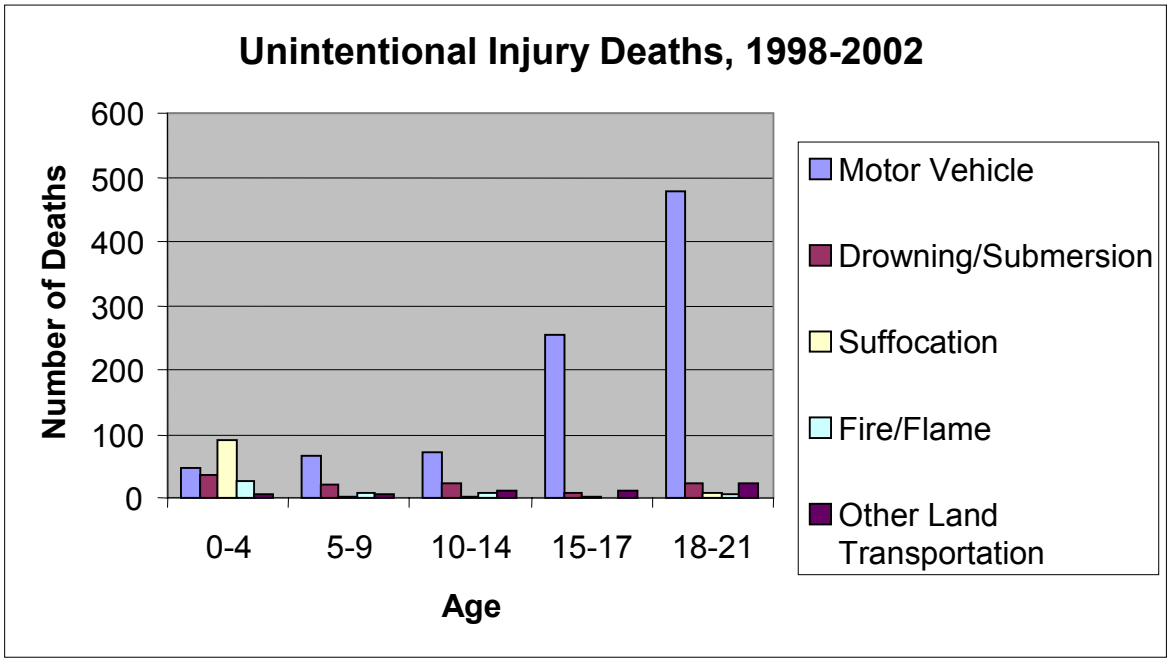
DATA DEPICTION-Wisconsin data[3]

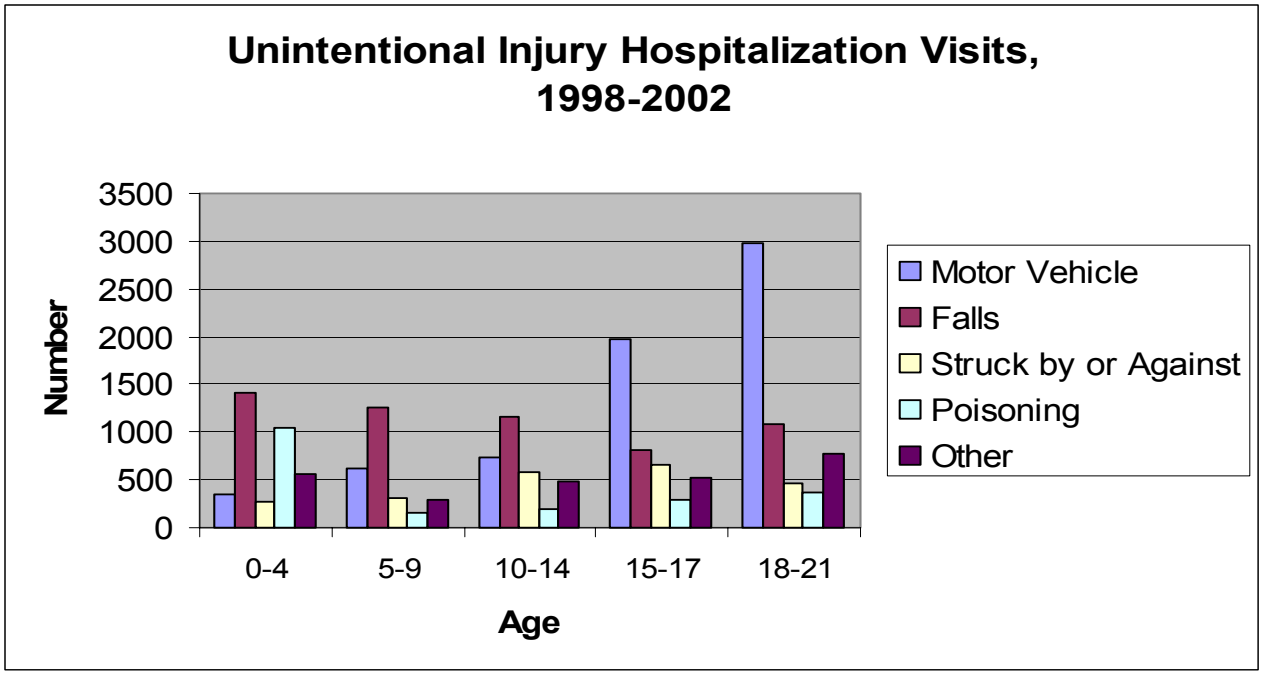
Number of Unintentional Deaths by Top 5 Causes (1998-2002)

	0-4	5-9	10-14	15-17	18-21
Motor Vehicle	48	65	71	253	479
Drowning/Submersion	37	22	23	8	24
Suffocation	89	4	4	4	8
Fire/Flame	27	9	8	1	6
Other Land Transportation	5	5	13	12	24

Number of Unintentional Hospitalizations by Top 5 Causes (1998-2002)

	0-4	5-9	10-14	15-17	18-21
Motor Vehicle	339	627	730	1,978	2,972
Falls	1,409	1,252	1,164	814	1,082
Struck by or Against	272	310	583	667	458
Poisoning	1,048	155	187	296	361
Other	561	294	481	519	773





REFERENCES

[1] National Committee for Injury Prevention & Control, 1989

[2] NHTSA: Pier Injury Prevention Curriculum: Module I: Injury Prevention Basics, October 2002

[3] Wisconsin Interactive Statistics on Health Query System (WISH), Mortality and Injury Hospitalization Modules, 1998-2003 (http://dhfs.wisconsin.gov/wish/). Bureau of Health Care Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Motor vehicle deaths and hospitalizations

DEFINITION

Number of motor vehicle deaths by age.
Number of motor vehicle hospitalizations by age.
Deaths and injuries that occur on Wisconsin roads and highways which involve at least one motor vehicle in transport and resulting in injury or death to any person, or damage to any property.

DESCRIPTION OF THE NEED

In 2002, there were 829 motor vehicle related deaths in Wisconsin, compared to 753 in 1998. Combined motor vehicle death data from 1998-2002 indicate that the age groups with the most deaths are in the 15-24 and 65-85+ age categories. The Emergency Department Motor Vehicle "related hospitalizations for 2002" also indicate the age group with the highest number of hospitalizations was 15-24 year olds.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:
Unintentional Injury Prevention

Healthiest Wisconsin 2010 Health Priority:
Intentional and Unintentional Injuries and Violence

Title V National Performance Measure:
Rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children

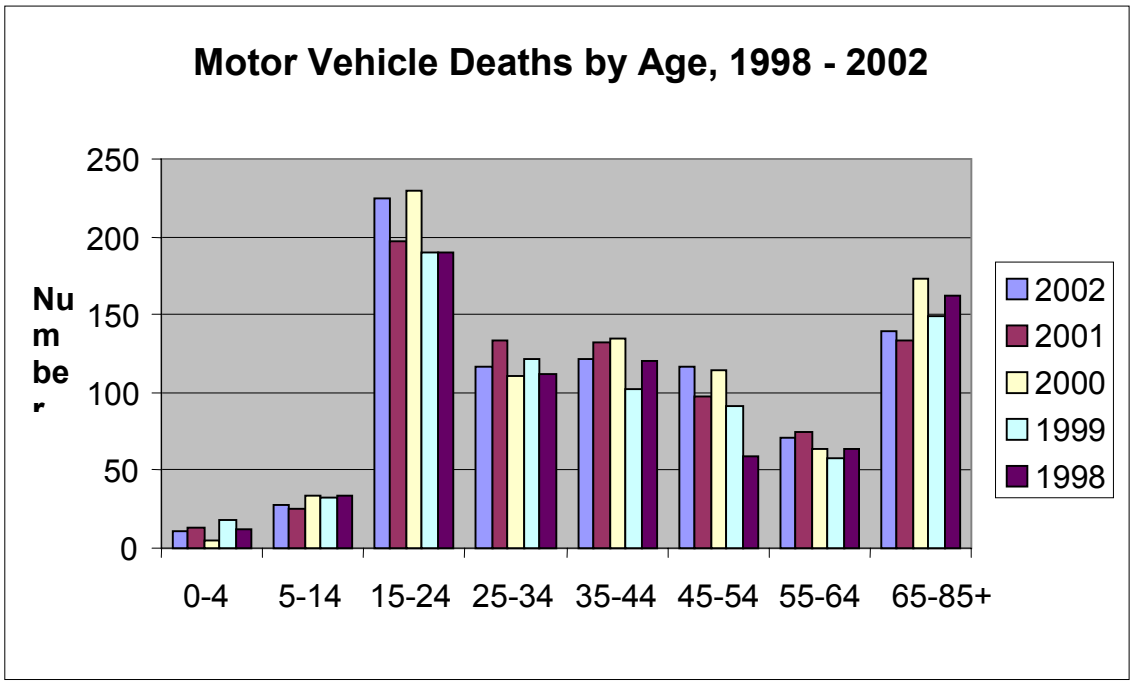
DATA DEPICTION

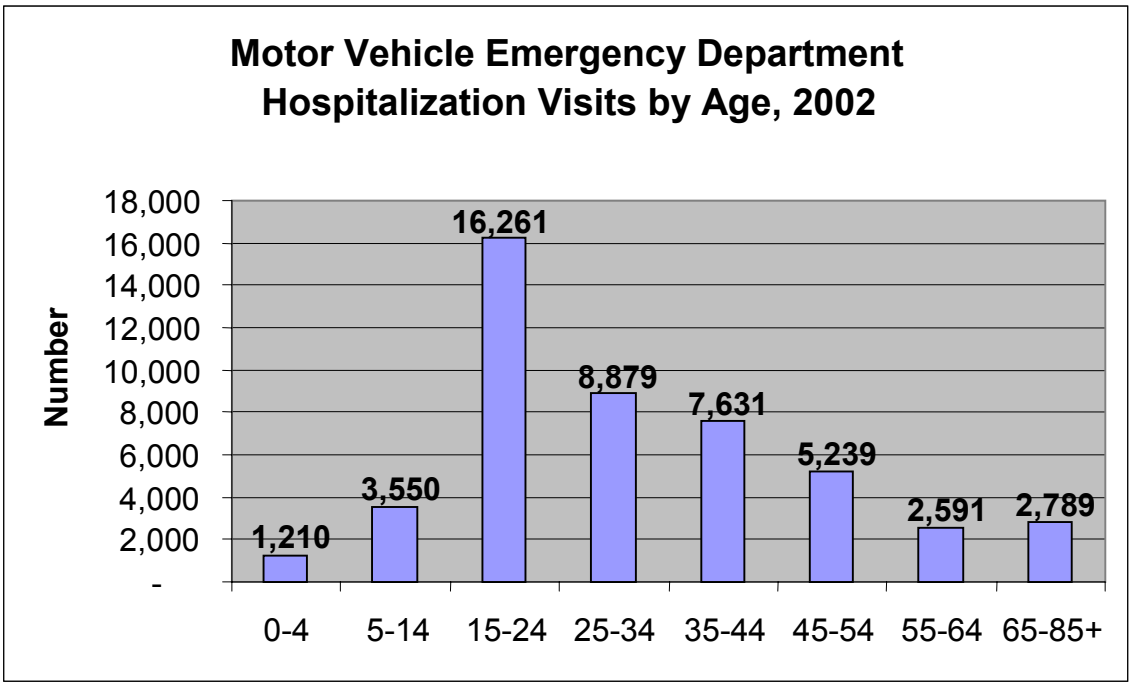
Number of Motor Vehicle Deaths by Age

	2002	2001	2000	1999	1998
0 - 4	11	13	5	18	12
5 - 14	28	25	34	32	34
15 - 24	225	197	229	190	190
25 - 34	117	133	111	121	112
35 - 44	121	132	135	102	120
45 - 54	117	97	114	91	59
55 - 64	71	74	64	58	64
65 - 85+	139	133	173	149	162

Number of Motor Vehicle Emergency Hospitalizations by Age, 2002

0 - 4	1,210
5 - 14	3,550
15 - 24	16,261
25 - 34	8,879
35 - 44	7,631
45 - 54	5,239
55 - 64	2,591
65 - 85+	2,789





DATA SOURCE

Data Source: Wisconsin Interactive Statistics on Health Query System (WISH), Injury Mortality and Injury Emergency Department Hospitalizations Modules, 1998-2002 (http://dhfs.wisconsin.gov/wish/). Bureau of Health Care Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services.

(11/05/04)

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Falls

DEFINITION

An event which results in a person coming to rest inadvertently on the ground or other lower level and other than as a consequence of the following: sustaining a violent blow; loss of consciousness; sudden onset of paralysis, as in a stroke; and an epileptic seizure.

DESCRIPTION OF THE NEED

Wisconsin's rate of unintentional deaths from falls has increased steadily over the past several years. Compared to other states, Wisconsin continues to rank in the Top Five when it comes to deaths from falls. Between the years of 1996-2002, there were over 3,000 deaths related to falls, and even more alarming are the over 109,000 hospitalizations related to fall injuries.

A report published by the National Safe Kids Campaign states that falls continue to be the leading cause of nonfatal unintentional injury among children. In 2000, more than 2.5 million children in this age group required hospital emergency room treatment for fall-related injuries.

Children ages 4 and under are at greatest risk of fall-related death and are twice as likely as children of other ages to die from falls. Fall hazards to children include unsafe baby walkers, lack of safety straps on child products, stairs, unsafe playgrounds, windows not equipped with window guards, and lack of supervised play both in and outside of the home.[2]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Injury Prevention

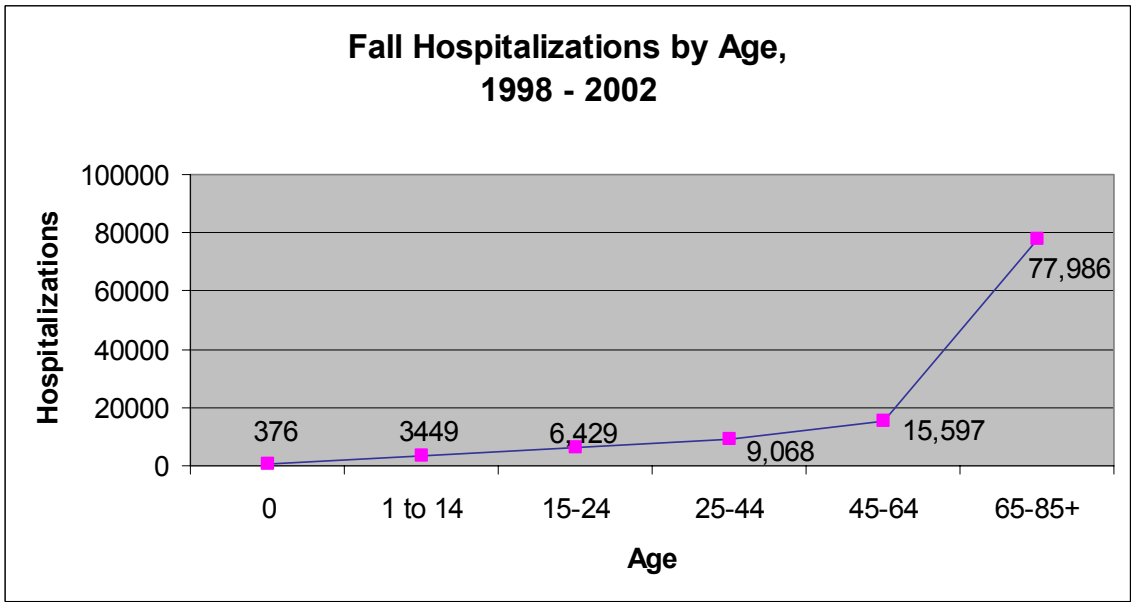
Healthiest Wisconsin 2010 Health Priority:

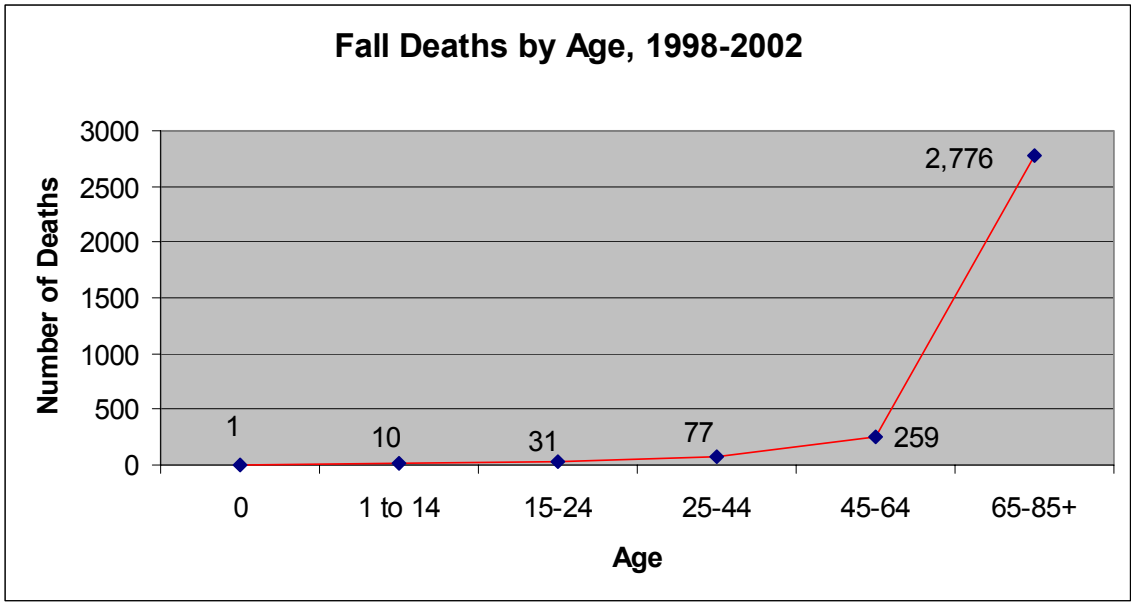
Intentional and Unintentional Injuries and Violence

DATA DEPICTION

Number of falls by age

Age	Hospitalizations	Deaths
0	376	1
1 - 14	3,449	10
15 - 24	6,429	31
25 - 44	9,068	77
45 - 64	15,597	259
65 - 85+	77,986	2,776





DATA SOURCE

[1] Wisconsin Interactive Statistics on Health Query System (WISH), Mortality and Injury Hospitalization Modules, 1998-2002 (http://dhfs.wisconsin.gov/wish/). Bureau of Health Care Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services.

[2] National Safe Kids Campaign, Report to the Nation: Trends in Unintentional Childhood Injury Mortality, 1987-2000, 2003

(11/05/04)

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Child passenger safety

DEFINITION

Child passenger safety refers to children riding restrained, following appropriate selection and proper installation of child safety seats. This indicator measures the percent of children age 8 years and under who ride unrestrained and the percent of child safety seats which are not installed or used correctly.

DESCRIPTION OF THE NEED

Despite increased use of child restraints and the heightened awareness of proper selection and installation of child safey seats, motor vehicle crashes remain the leading cause of death in children 1-14 years of age. Riding unrestrained is a major risk factor for death and injury among those child occupants of motor vehicles. The correct installation of child safety seats is often confusing to parents, grandparents, and caregivers. New technology in child safety seats and in vehicles adds to this confusion. Child safety seats when correctly installed and used in passenger cars reduce the risk of death by 71% for infants, 54% for children ages 1 to 4, and reduces the need for hospitalization by 69% for children ages 4 and under.[1]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Unintentional Injury Prevention

Healthiest Wisconsin 2010 Health Priority:

Intentional and Unintentional Injuries and Violence

DATA DEPICTION

National data shows that an estimated 14% of children ages 14 and under ride unrestrained and 55% of those children, killed as motor vehicle occupants in 2001, were unrestrained. In addition, nearly one-third of children ride in the wrong restraint for their size and age, and approximately 82% of child safety seats are installed or used incorrectly.[1] National data is similar to data reported by the Wisconsin Department of Transportation which states that more than 80% of child safety seats are not used correctly.[2]

DATA SOURCE

[1] National Safe Kids Campaign, Report to the Nation: Trends in Unintentional Childhood Injury Mortality 1987-2000.

[2] Wisconsin Department of Transportation website http://www.dot.wisconsin.gov/safety/vehicle/ (Safety--Vehicles and Equipment)

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Dental caries

DEFINITION

Percent of children ages 6 to 8 with untreated decay: at least one primary or permanent tooth with an untreated cavity.

DESCRIPTION OF THE NEED

Statewide 30.8% of the children had untreated decay: at least one primary or permanent tooth with an untreated cavity. Compared to white children, a significantly higher proportion of minority children had caries experience and untreated decay. Twenty-five percent of the White children screened had untreated decay compared to 50% of the African American, 45% of the Asian, and 64% of the American Indian children. In addition, children surveyed who attended lower income schools had significantly more untreated decay (44.5%) compared to children in both middle (31.7%) and higher income schools (16.6%).[1]

SERIOUSNESS OF THE PROBLEM

Oral health is integral to general health. Dental caries is an infectious, communicable disease and is the single most common chronic childhood disease. Oral diseases, including dental caries, are progressive and cumulative and become more complex over time. If the caries infection in enamel goes unchecked, the acid dissolution can advance to form a cavity that can extend through the dentin (the component of the tooth located under the enamel) to the pulp tissue. The resulting toothache can be severe and often is accompanied by sensitivity to temperature and sweets. If untreated, the pulp infection can lead to abscess, destruction of bone, and spread of the infection via the bloodstream. Dental caries can affect our ability to eat, the foods we choose, how we look, and the way we communicate. This disease can affect economic productivity and compromise our ability to work at home, at school, or on the job.[2] There are striking disparities in dental disease by income. Poor children suffer twice as much dental caries as their more affluent peers, and their disease is more likely to be untreated.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Oral Health

Healthiest Wisconsin 2010 Health Priority:

Access to primary and preventive health services

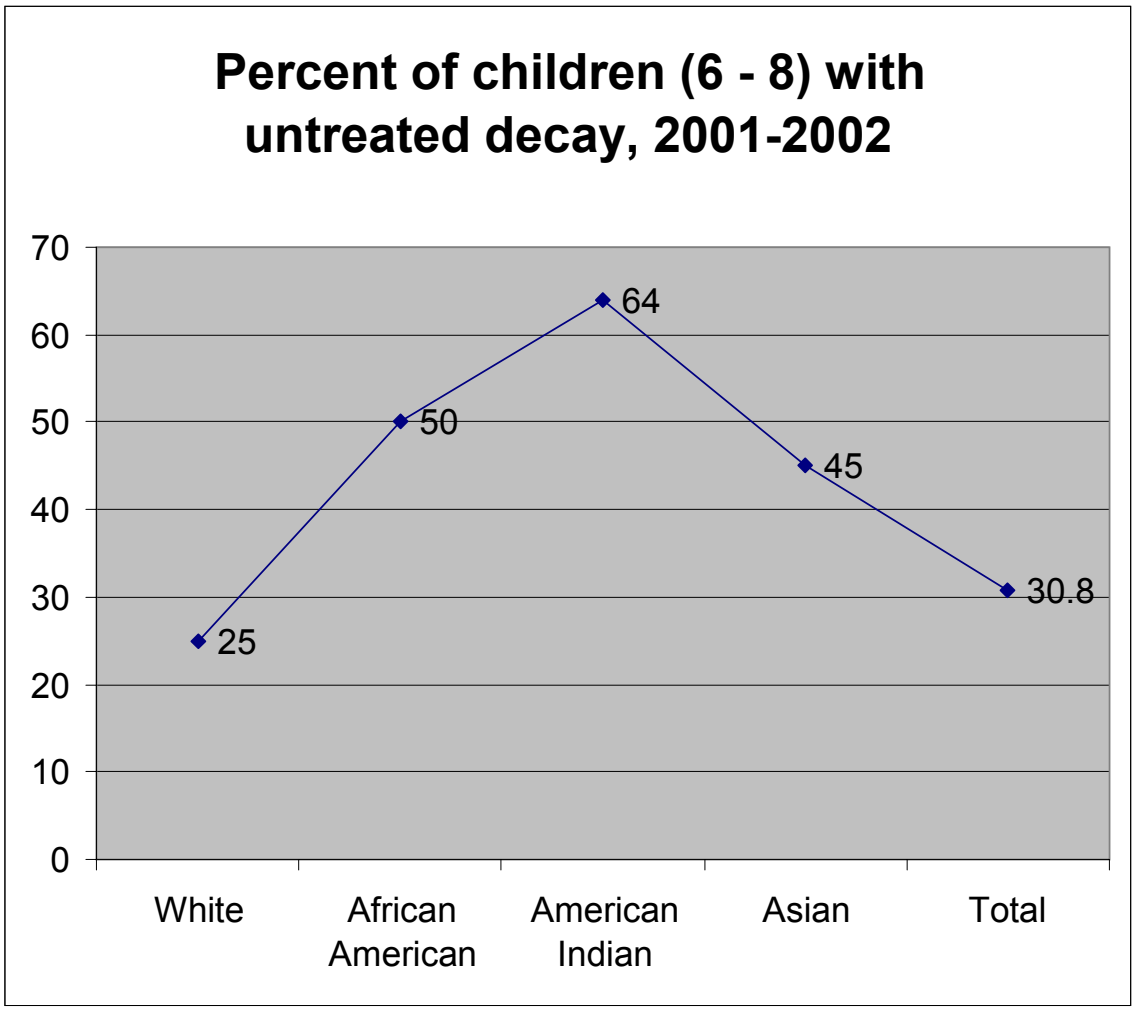
Title V State Performance Measure:

Percent of children, ages 6-8, with untreated dental decay in primary and permanent teeth

DATA DEPICTION

Wisconsin: Percent of children (6-8) with untreated decay, 2001-2002[1]

	2001-2002
White	25%
African American	50%
American Indian	64%
Asian	45%
Total	30.8%



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[1] Wisconsin Department of Health and Family Services. Make Your Smile Count Survey Report, 2001-2002.

[2] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Lead blood levels in young children

DEFINITION

Percent of children ages 0-5 who have been tested and have blood lead levels >10 μg/dL.

DESCRIPTION OF THE NEED

In 2002, 4.5% of Wisconsin children less than 6 years of age who were tested, had a blood lead level of 10 μg/dL or more. There are 13 high-risk communities in Wisconsin accounting for 82% of all lead-poisoned children. Risk factors for increased risk of lead poisoning are: 1) family income–the risk to children enrolled in Medicaid are 3 times higher than those not enrolled; 2) race/ethnicity–rates are highest among African American children, followed by Asian and Hispanic children; 3) age of children–blood lead levels are highest among children 18-36 months of age; and 4) age of house–90% of lead poisoned children live in pre-1950 housing.[1]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Toxics and Waste

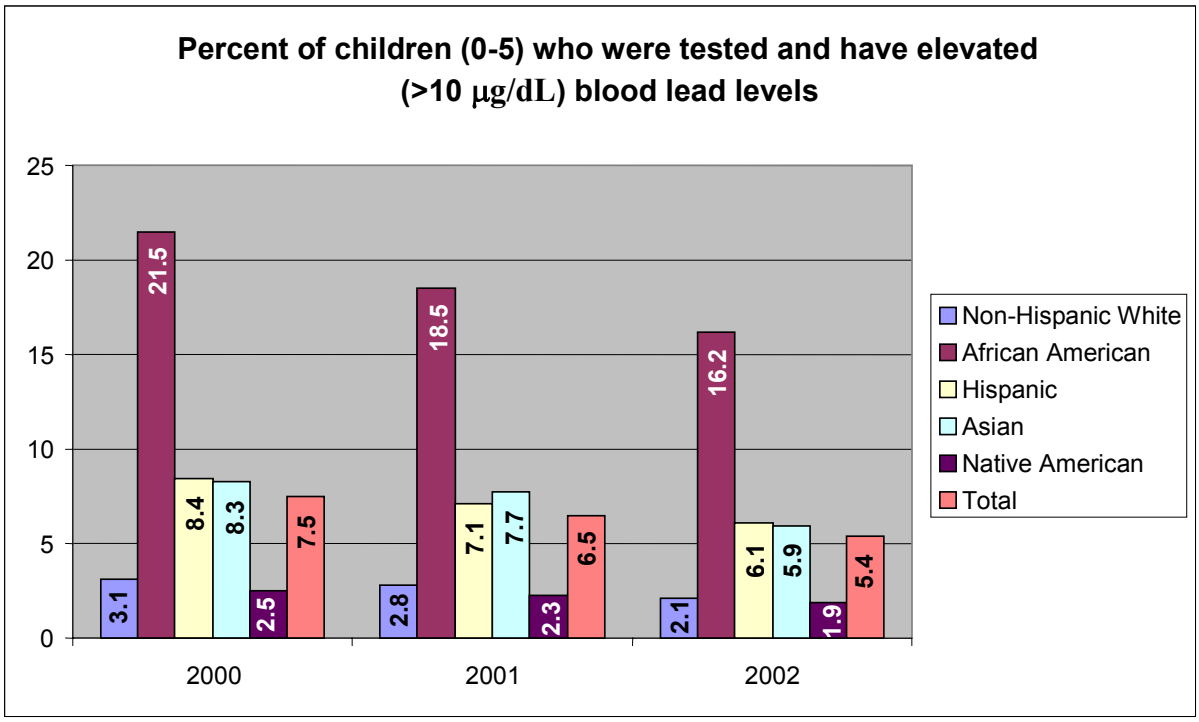
Healthiest Wisconsin 2010 Health Priority:

Environmental and occupational health hazards

DATA DEPICTION

Percent of children ages 0-5 who have been tested and have elevated (>10 μg/dL) blood lead levels.

Race / Ethnicity	2000	2001	2002	2003
Non-Hispanic White	3.1	2.8	2.1	na
African American	21.5	18.5	16.2	na
Hispanic	8.4	7.1	6.1	na
Asian	8.3	7.7	5.9	na
Native American	2.5	2.3	1.9	na
Total	7.5	6.5	5.4	4.5



DATA SOURCE

[1] Wisconsin Department of Health and Family Services. Division of Public Health, Bureau of Environmental Health, Lead Program, 2004.

Wisconsin Department of Health and Family Services, Division of Public Health. Bureau of Environmental and Occupational Health, Wisconsin Childhood Lead Poisoning Prevention Program, annual reports.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Comprehensive coordinated school health programming

DEFINITION

A comprehensive school health program coordinates eight components: 1) health services; 2) health education; 3) efforts to ensure healthy physical and social environments; 4) nutrition services; 5) physical education and other activities; 6) counseling and psychological, and social services; 7) health programs for faculty and staff; and 8) collaborative efforts of schools, families, and communities to improve the health of students, faculty, and staff.

School Health Education Profiles survey data can identify existing local education and health policies including: tobacco-use-prevention, nutrition, violence-prevention, health education, and physical education and physical activity[1].

DESCRIPTION OF THE NEED

In the United States, 53 million young people attend nearly 129,000 schools for about 6 hours of classroom time each day during the most formative year of their lives[2]. More than 95% of young people aged 5-17 years are enrolled in school. Therefore, supporting school health programs to improve the health status of young people has never been more important. The health of young people and the adults they will become is critically linked to the health-related behaviors they choose to adopt.

Certain behaviors that are often established during youth contribute to major causes of death as adults. These behaviors include: using tobacco; eating unhealthy foods; not being physically active; using alcohol and other drugs; engaging in sexual behaviors that cause HIV infection, other sexually transmitted diseases, and unintended pregnancies; and engaging in behaviors that can result in violence or unintended injuries. States conduct a Youth Risk Behavior Survey (YRBS) every 2 years among representative samples of 9th through 12th grade students.

In *Healthy People 2010* there are 21 critical objectives for adolescents and young adults, four relate directly to chronic disease prevention. In addition, there are 10 federal objectives that focus on the schools in improving the health of young people.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Educational and Community-Based Programs

DATA DEPICTION

There is no baseline data available. Need to develop a survey to identify local education and health policies including: tobacco-use-prevention, nutrition, violence-prevention, health education, physical education, and physical activity.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Abstinence from adolescent sexual activity

DEFINITION

Abstinence from adolescent sexual activity is measured by the Wisconsin Youth Risk Behavior Survey as a decrease in the percent of Wisconsin high school youth who report ever having sexual intercourse.

DESCRIPTION OF THE NEED

It is important to capitalize on the willingness of teens to adopt the protective behavior of delaying sex. From 1993 to 2003, the percent of Wisconsin high school youth who reported ever having sex decreased from 47% in 1993 to 37% in 2003. The percent of Wisconsin high school seniors who reported ever having sex decreased from 66% in 1993 to 51% in 2003.[5] A 2003 survey, 92% of teens say teens should receive a strong message from society to delay sex until *at least* after high school.[6]

Teen parenthood is associated with poverty, abuse, alcohol and drug use, domestic violence, mental health issues, and school failure. Sons of adolescent mothers are more likely to go to prison (cost of $1 billion each year for prisons).[1] About one in four sexually experienced teens contracts a sexually transmitted infection each year.[2] The earlier an adolescent or young adult begins having sex, the more likely he or she is to have multiple sexual partners (see chart and next bullet).[3]

Age at Initiation of Sexual Activity may increase number of partners, which increases likelihood of contracting sexually transmitted infections		
If a girl or woman's age at first intercourse was:	**Percent who had only 1 lifetime partner if they initiated sex at this age:**	**Percent who had more than 5 lifetime partners if they initiated sex at this age:**
15 years old or younger	11.3%	58.1%
17 years old	17.3%	44.4%
19 years old	37.6%	27.4%
Older than 20 years old	52.2%	15.2%

According to the Institute of Medicine, "The greater the number of partners an individual has, the greater the risk of exposure [to sexually transmitted infection]. This association may be due to the increased risk of exposure to an infected partner with increasing number of partners and the fact that having multiple partners may be associated with other risk factors such as high-risk partners and less consistent use of condoms."[4]

Adults may increase the likelihood that a teen will delay sex through the following strategies:

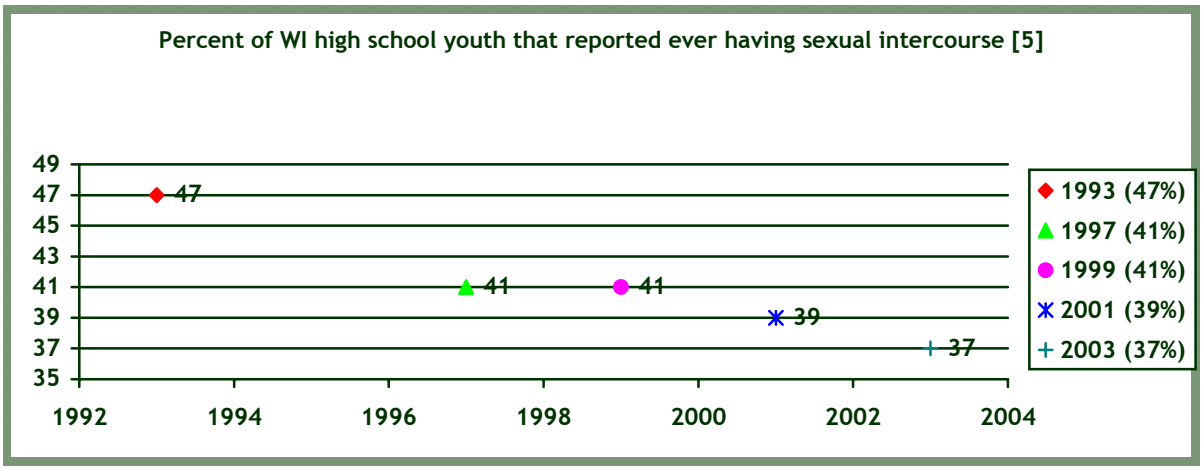
- Contribute to an increase in scholastic achievement, parent/family connectedness, and friendships with peers who support the avoidance of risk behaviors,[7]
- Facilitate discussions between parents and youth about sex,[7]
- Apply findings from *Emerging Answers* such as giving youth a clear message about the benefits of the proposed behavioral change; using an approach that is appropriate to the age, sexual experience and culture of youth served; presenting the risks of sexual activity; teaching about social pressures and refusal and communication skills and allowing youth to participate and personalize the information; including at least 14 hours of instruction; and training leaders who are enthusiastic about abstinence education.[8]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:
Family Planning

Healthiest Wisconsin 2010 Health Priority:
High Risk Sexual Behavior

DATA DEPICTION



DATA SOURCE

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WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Alcohol use by any age group

DEFINITION

Percent of adults (18-54) who had 5 or more drinks on one occasion.
Percent of high school youth who had at least one drink of alcohol on one or more of the past 30 days.

DESCRIPTION OF THE NEED

Chronic drinking is a risk factor for liver disease. Both acute and chronic drinking and "drinking and driving" increase the likelihood of injuries from car accidents, falls and other causes. From 1993 to 2003, fewer school age adolescents experimented with alcohol before the age of 13 (25% compared to 37% respectively).[1] This improvement is very significant as early onset of alcohol use before the age of 13 is good predictor for increased use of alcohol and other illicit substances in the succeeding years.

A second area of concern is binge drinking (5 or more drinks of alcohol in a row in the past 30 days). Students in 2003 reported alcohol consumption levels comparable to the 1993 levels (28% compared to 29% respectfully. The trend over the ten-year period had gone as high as 34%. Wisconsin's data is close to the National data where 30% of students reported binge drinking in the past 30 days. A concerted effort is needed in the area of consistent enforcement and coordination of existing policies, increased education and public awareness and fundamental shift in the public perception of use of alcohol but especially among school age youth.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:
Substance Use and Abuse

Healthiest Wisconsin 2010 Health Priority:
Alcohol and other substance use and addiction.

Title V State performance Measure:
Percent of high school youth who self-report taking a drink in the past 30 days

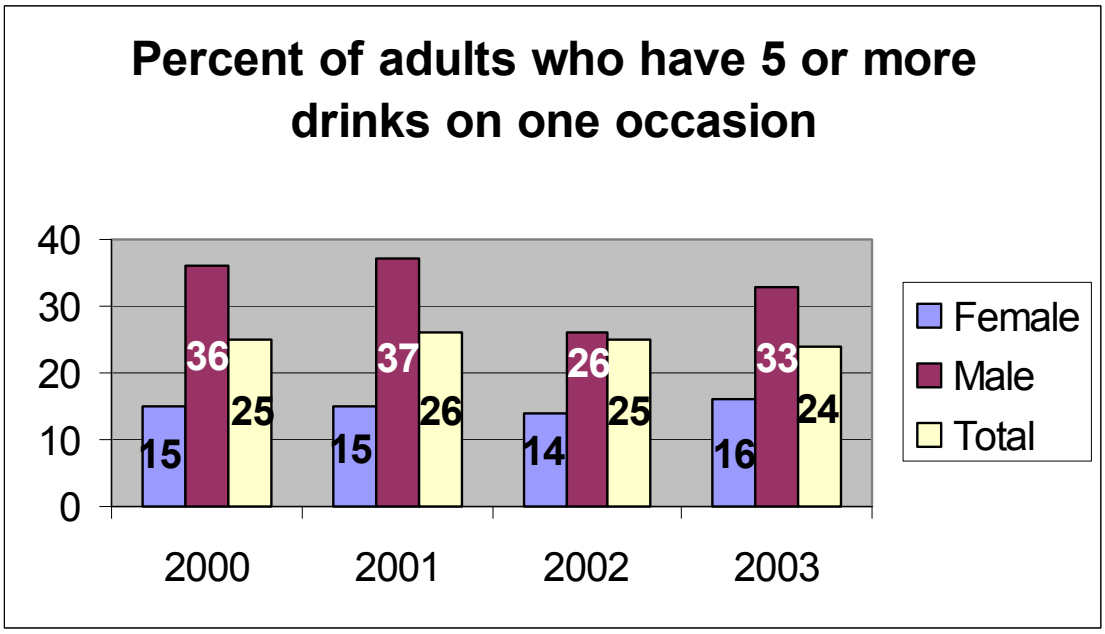
DATA DEPICTION

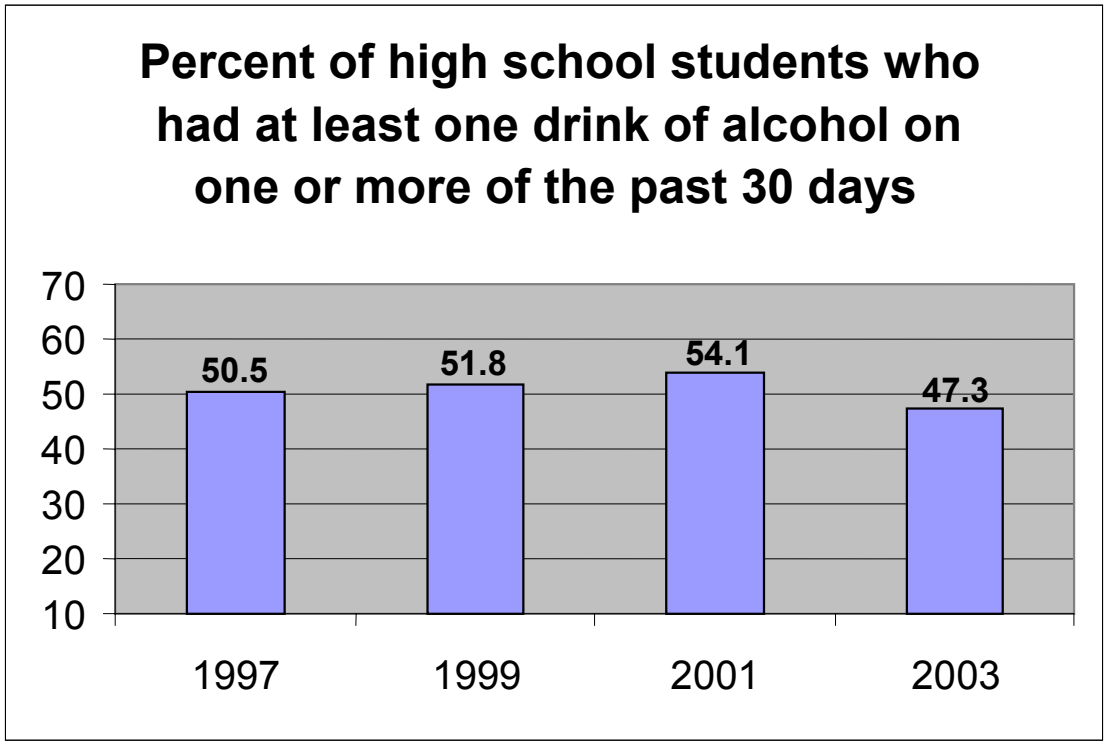
Percent of adults who had 5 or more drinks on one occasion

	2000	2001	2002	
Female	15%	36%	25%	
Male	15%	37%	26%	
Total	14%	26%	25%	

Percent of high school students who had at least one drink of alcohol on one or more of the past 30 days

1997	1999	2001	2003
50.5%	51.8%	54.1%	47.3%





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WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Tobacco use among youth

DEFINITION

Percent of middle and high school youth who report smoking cigarettes past month (30 days).

DESCRIPTION OF THE NEED

Overall, youth cigarette smoking increased in both the United States and Wisconsin in the 1990s, but starting in 2000, youth smoking rates began to steadily decline. In Wisconsin, the percent of middle school students who have ever smoked decreased from a high of 16.1% in 2000 to 12.8% in 2002.[1] The percent of Wisconsin high school students who are current smokers declined from a high of 38% in 1999 to 27% in 2002.

The current smoking rate in Wisconsin high schools in 2002 is slightly lower than what would have been predicted if the state had continued its trend from the previous years. Despite these reductions in Wisconsin, the almost 80% of 6th graders who have never smoked a cigarette drops to 30% by 12th grade.

Key Wisconsin state tobacco prevention strategies such as monitoring prevalence, age of initiation, access, succession, secondhand smoke, and media awareness must be maintained.

SERIOUSNESS OF THE PROBLEM

The short-term health effects of smoking among young people include damage to the respiratory system, nicotine addiction, and the associated risk of other use of drugs. The long-term health consequences are reinforced by the fact that most young people who smoke, continue this habit throughout adulthood.[2]

Teens who smoke are three times more likely than nonsmokers to use alcohol, eight times more likely to use marijuana, and 22 times more likely to use cocaine. Smoking is associated with a host of other risky behaviors, such as fighting and engaging in unprotected sex.[2]

Smoking is also associated with overall poor health and a variety of short-term adverse health effects.[3] Smoking may also be a marker for underlying mental health problems among adolescents such as depression. High school seniors who smoke in the ninth grade:

- Are 2.4 times more likely than their nonsmoking peers to report poorer overall health.
- Are 2.4 to 2.7 times more likely to report cough with phlegm or blood, shortness or breath when not exercising, and wheezing or gasping.
- Are 3.0 times more likely to have seen a doctor or other health professional for an emotional or psychological complaint.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Tobacco

Healthiest Wisconsin 2010 Health Priority:

Tobacco Use and Exposure

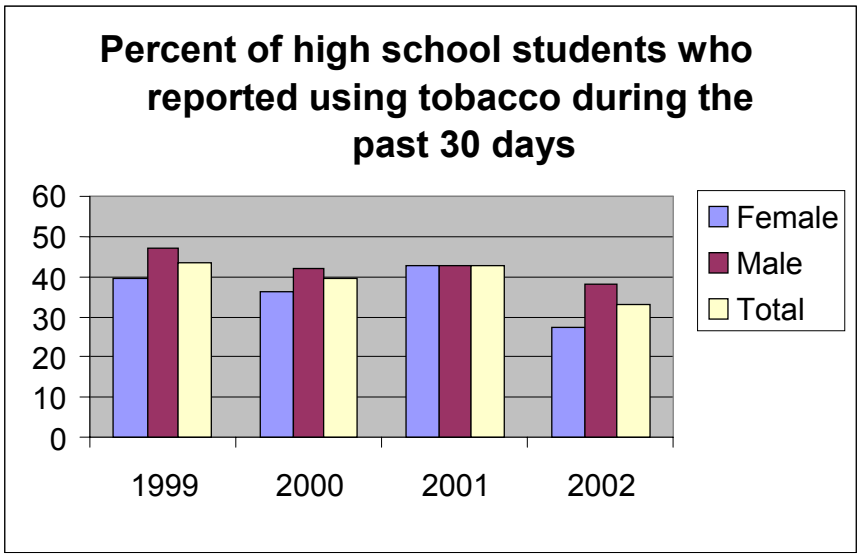
DATA DEPICTION –– Wisconsin data[1]

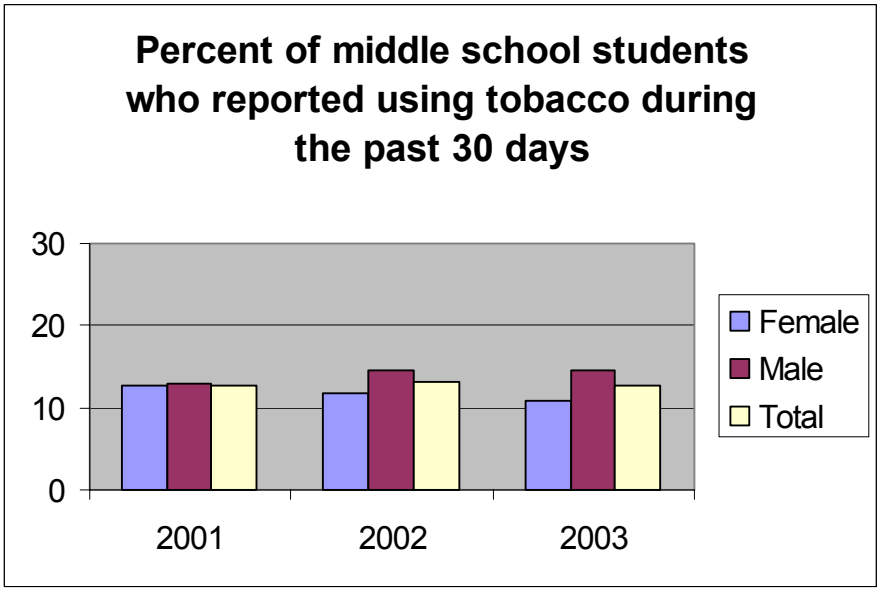
Percent of middle school youth who reported using tobacco during the past 30 days

WI	Female	Male	Total
2001	12.6%	13.0%	12.8%
2002	11.8%	14.5%	13.2%
2003	10.8%	14.5%	12.8%

Percent of high school youth who reported using tobacco during the past 30 days

WI	Female	Male	Total
1999	39.6%	47.4%	43.7%
2000	36.2%	42.1%	39.4%
2001	42.4%	42.7%	42.6%
2002	27.3%	38.2%	32.9%





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Enhanced *(03/25/05)*

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Overweight and at risk for overweight

DEFINITION

Data on children were gathered from children enrolled in the Wisconsin Special Supplemental Nutrition Program for Women, Infants and Children (WIC) who are overweight and at risk of overweight.

- Overweight: Based on the 2000 CDC growth chart percentiles of greater than or equal to the 95th percentile weight-for-length for children less than 2 years of age, and greater than the 95th percentile BMI-for-age for children 2 years of age or older.
- Risk of Overweight: Based on the 2000 CDC growth chart percentiles of the 85th to the 95th percentile BMI-for-age for children 2 years of age or older.

Data on youth were gathered from the question on the Wisconsin Youth Risk Behavior Survey (YRBS): How do you describe your weight?

DESCRIPTION OF THE NEED-Wisconsin Data

Overweight in children and youth has reached epidemic proportions in recent years.

- Data for Wisconsin Pediatric Nutrition Surveillance System (PedNSS) were collected from children enrolled in WIC; this represents approximately 40% of all children (approximately 80% of all minority children) under five years of age in Wisconsin. The prevalence of overweight in children in the 2003 PedNSS from birth to age 5 is 12.2%. Overweight in children younger than age 2 does not pose the same risk as it does in children aged 2 or older because little association has been found between their weight and increased risk for adult obesity. Overweight and at-risk-for-overweight has increased among all racial and ethnic groups. The prevalence of overweight for children aged 2 or older increased from 8.9% in 1994 to 13.0% in 2003. The prevalence of at risk-for-overweight for children aged 2 to 5 or older increased from 13.8% in 1994 to 15.9% in 2003. In 2003, the highest rates for overweight and at-risk-for-overweight were among American Indian (19.2% and 20.0%), Asian (18.3% and 17.8%), and Hispanic (17.8% and 17.6%). Rates for White were slightly lower at 11.8% and 15.9% and Black at 10.1% and 13.6%.[1,3]
- Data on body image from the 2003 YRBS indicate that 28% of youth described their weight as slightly overweight and 4% described their weight as very overweight.[2]

SERIOUSNESS OF THE PROBLEM

Immediate Risks of Obesity to a Child's Health

Young people are at risk of developing serious psychosocial burdens related to being obese in a society that stigmatizes this condition, often fostering shame, self-blame, and low self-esteem that may impair academic and social functioning and carry into adulthood. In a population based sample, approximately 60% of obese children aged 5 to 10 years had at least one cardiovascular disease (CVD) risk factor—such as elevated total cholesterol, triglycerides, insulin, or blood pressure—and 25% had two or more risk CVD risk factors.

Long-Term Risks of Obesity to a Child's Health

For children born in the United States in 2000, the lifetime risk of being diagnosed with type 2 diabetes at some point in their lives is estimated to be 30% for boys and 40% for girls, and the lifetime risk for developing type 2 diabetes is even higher among ethnic minority groups at birth and at all ages. Type 2 diabetes is rapidly becoming a disease of children and adolescents. In case reports limited to the 1990s, type 2 diabetes accounted for 8% to 45% of all new pediatric cases of diabetes—in contrast with fewer than 4% before the 1990s. The obesity epidemic may reduce overall adult life expectancy because it increases lifetime risk for type 2 diabetes and other serious chronic disease conditions, thereby potentially reversing the improved life expectancy trend achieved with the reduction of infectious diseases over the past century. Obesity can also lead to metabolic syndrome, arthritis, cancer, and CVD.[4]

A recent press release from the National Institutes of Health suggests that younger Americans will face a greater risk of mortality throughout life than previous generations. Over the next few decades, life expectancy for the average American could decline by as much as 5 years unless major efforts are made to slow rising rates of obesity. Studies show that two-thirds of American adults are overweight or obese. Additional research has shown that people who are severely obese (BMI >45), live up to 20 years less that people who are not overweight. Some researchers estimate that obesity causes about 300,000 deaths in the U.S. annually.[5]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Weight Status and Growth

Healthiest Wisconsin 2010 Health Priority:

Overweight, obesity, and lack of physical activity
Adequate and appropriate nutrition

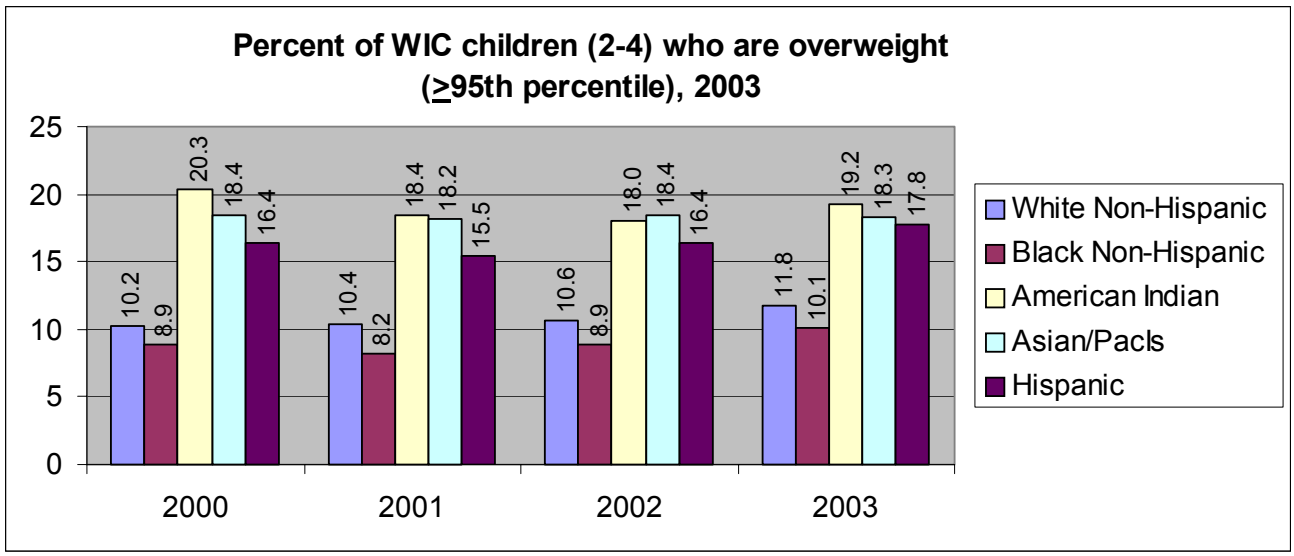
Title V State Performance Measure:

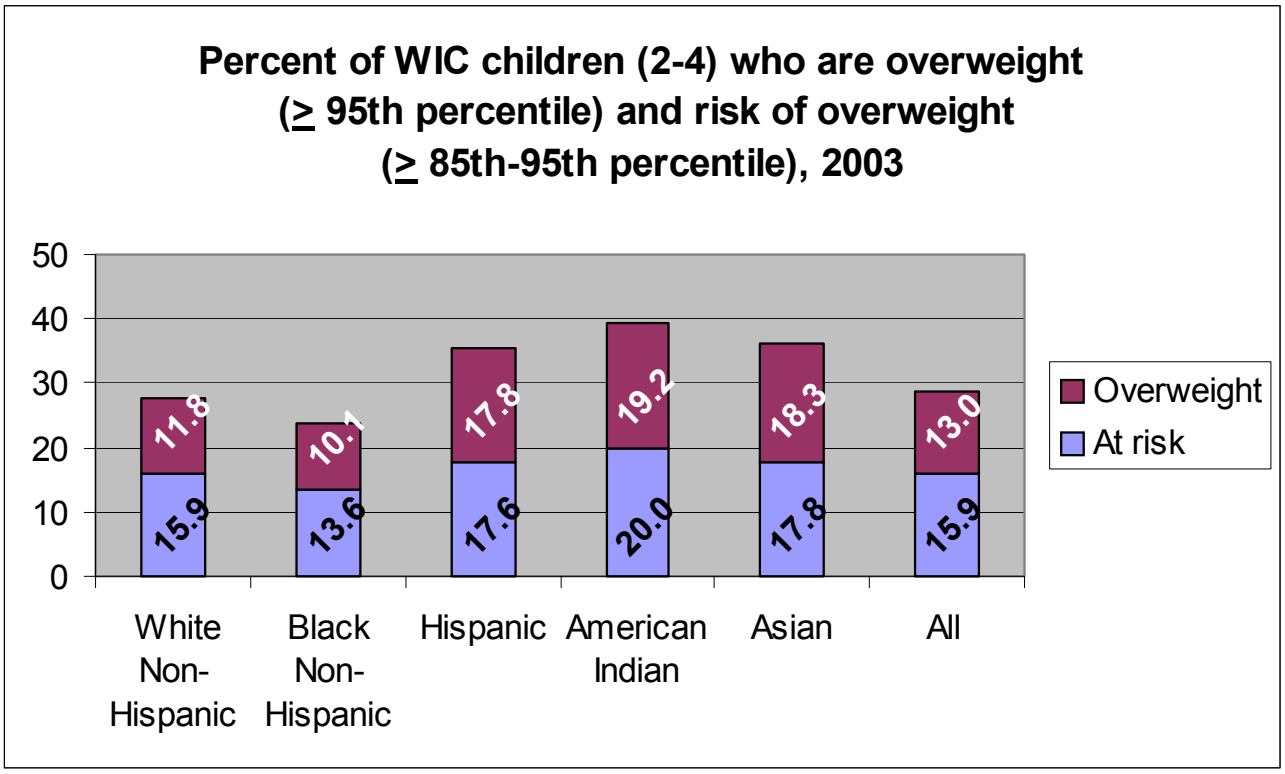
Percent of children, ages 2-4, who are overweight

DATA DEPICTION - – Wisconsin data[2,3]

Percent of children enrolled in WIC, ages 2-4, who are overweight (>= 95th percentile)[3]

Race / Ethnicity	2000	2001	2002	2003
White Non-Hispanic	10.2%	10.4%	10.6%	11.8%
Black Non-Hispanic	8.9%	8.2%	8.9%	10.1%
American Indian	20.3%	18.4%	18.0%	19.2%
Asian/Pacific Island	18.4%	18.2%	18.4%	18.3%
Hispanic	16.4%	15.5%	16.4%	17.8%





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[5] National Institutes of Health released March 16, 2005: Obesity Threatens to Cut U.S. Life Expectancy. http://www.nia.nih.gov/NewsAndEvents/PressReleases/PR20050316Obesity.htm

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Physical activity

DEFINITION

Percent of adults (ages 18-54) who have engaged in leisure-time physical activity in the past month.
Percent of high school youth who have engaged in moderate* physical activity in the past 7 days.
*Moderate means activities that did not make students sweat or breathe hard.

DESCRIPTION OF THE NEED

Millions of Americans suffer from chronic diseases that can be prevented or improved through regular physical activity. Regular physical activity substantially reduces the risk of cardiovascular disease, colon cancer, diabetes, obesity and high blood pressure. Regular physical activity also helps treat a variety of common illnesses, including arthritis, blood lipid disorders, diabetes, obesity and cardiovascular disease.[1] Data from the 2003 Behavior Risk Factor Survey (BRFSS) indicate that only 54.7% of Wisconsin adults meet the recommended guideline (at least 30 minutes on 5 or more days per week) for moderate physical activity.[2] For Wisconsin high school youth, 2003 data from the Youth Risk Behavior Survey (YRBS) show only 28% participated in moderate physical activity for ≥30 minutes on at least 5 of the past 7 days.[3]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:
Physical Activity

Healthiest Wisconsin 2010 Health Priority:
Overweight, Obesity, and Lack of Physical Activity

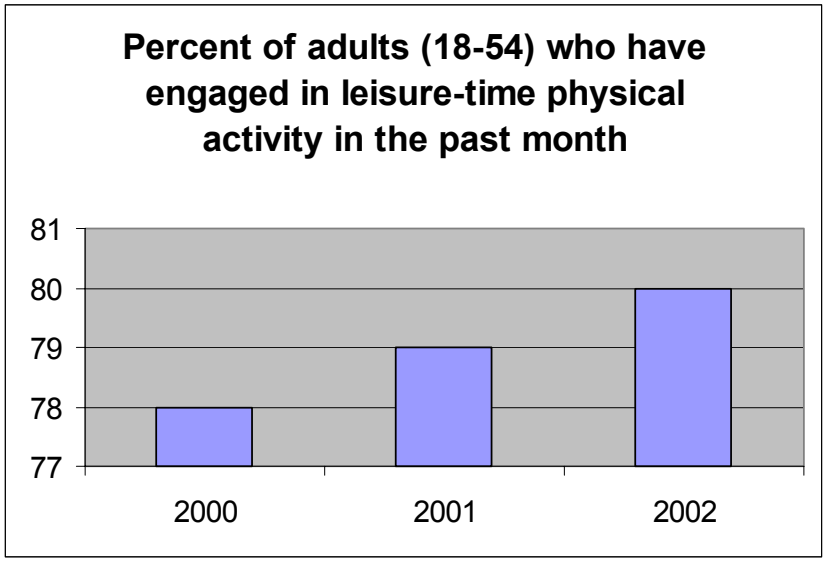
DATA DEPICTION

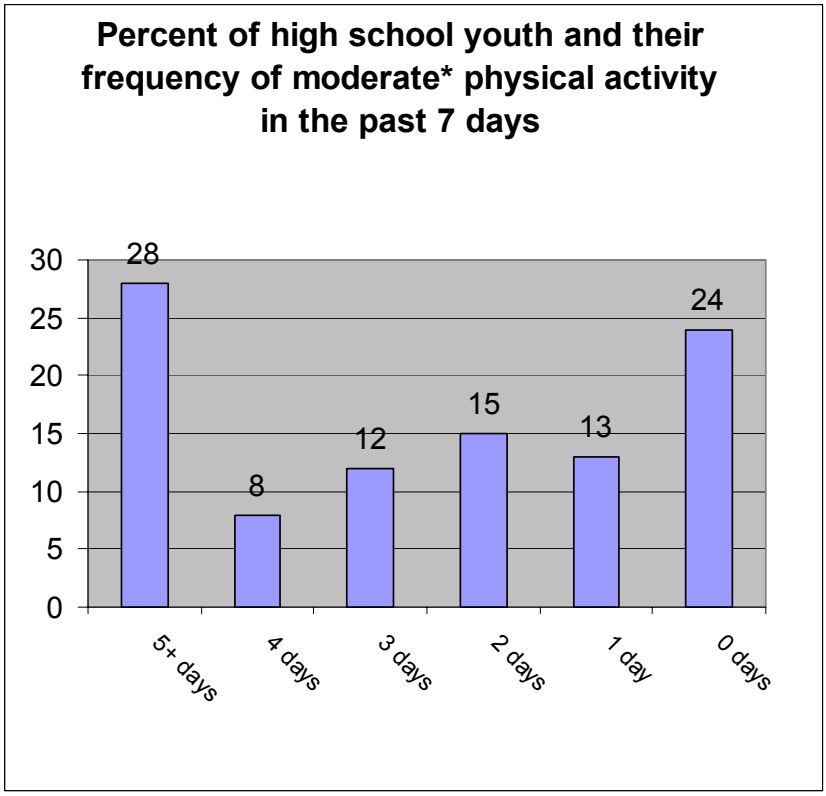
Percent of adults (18-54) who have engaged in leisure-time physical activity in the past month.

2000	2001	2002
78%	79%	80%

Percent of high school youth and their frequency of moderate physical activity in the past 7 days, 2003.

5 or more days ... 28%
4 days 8%
3 days 12%
2 days 15%
1 day 13%
0 days 24%





DATA SOURCE

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[3] Wisconsin Department of Public Instruction. 2003 Wisconsin Youth Risk Behavior Survey. Executive Summary.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Fruit and vegetable consumption

DEFINITION

Percent of adults that consume at least 5 servings of fruits and vegetables per day (BRFSS).
Percent of high school students that consume at least 5 servings of fruits and vegetables per day.

DESCRIPTION OF THE NEED

The growing concern about unhealthy diets, in large part, is related to the burden of chronic disease. Unhealthy diets, such as those high in fat, low in fiber, and low in fruits and vegetables, are associated with an increased risk for the top three causes of death in the country: heart disease, cancer, and stroke. Unhealthy diets can also lead to overweight and obesity, hypertension, diabetes, and osteoporosis.[1] Data from the 2003 YRBS indicate 34% of students reported eating 3 or more servings of fruit and only 18% reported eating 3 or more serving of vegetables on the day prior to the survey. Data from the 2003 BRFS indicate that only 21.5% of adults consume the recommended number of servings of fruits and vegetables (5 or more servings per day).

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:
Food and Nutrient Consumption

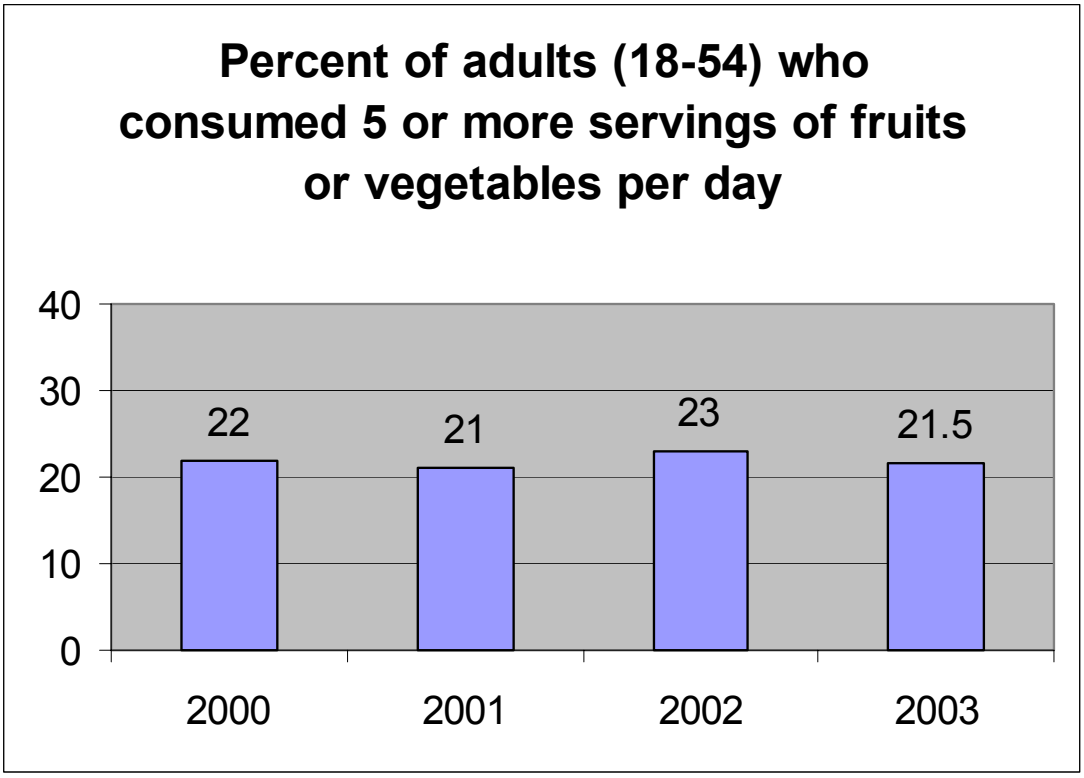
DATA DEPICTION

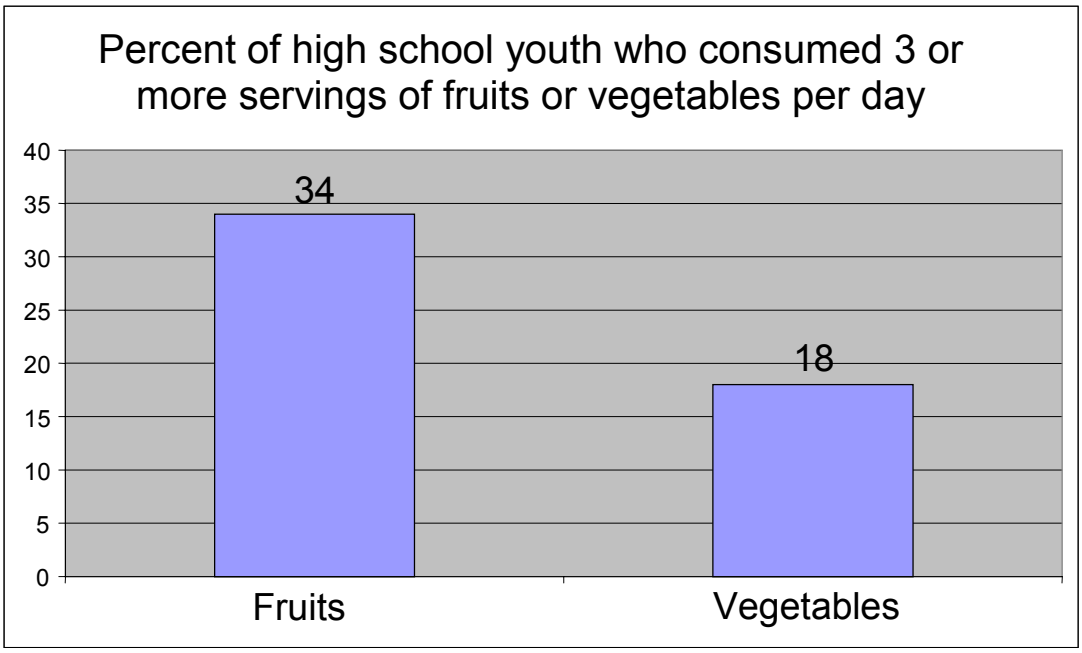
Percent of adults who consumed 5 or more servings of fruits or vegetables per day.[2]

2000	2001	2002
22%	21%	23%

Percent of high school students who consumed 3 or more servings of fruits or vegetables during the past day in 2003.[3]

2003	Fruits	Vegetables
Percent	34%	18%





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WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Infant and early childhood mental health

DEFINITION

Infant and early childhood mental health[1] is described as the developing capacity of the child from birth to age 3 to:

- experience, regulate, and express emotions;
- form close and secure interpersonal relationships; and
- explore the environment and learn.

DESCRIPTION OF THE NEED

Infant and young child mental health is synonymous with healthy social and emotional development.[1] Issues in infant and early childhood mental health are significantly different than mental health issues for older children and adults because of the total dependence infants and young children have on adults and the importance of that relationship to the mental and physical health of the child. However, even with the best practices in parenting, health care, socioeconomic conditions, and family support, some young children may be diagnosed with mental, behavioral, developmental, or emotional needs requiring early intervention and specialized care. Infant mental health, though rooted in the assurance of nurturing relationships for all young children, also incorporates those with needs that aren't or can't be met only by nurturing. The Governor's KidsFirst Plan addresses the need to promote early childhood mental health.[2]

Infant mental health focuses on several complementary issues: (1) promoting a healthy bond between the child and caregivers, (2) assessing and promoting healthy social and emotional development, (3) developing intervention services for children at risk of poor developmental outcomes because of family issues such as domestic violence and substance abuse, and (4) provision for specialized treatment for children and families who need intensive help because of abuse or neglect or a diagnosed emotional or behavioral disorder.

SERIOUSNESS OF THE PROBLEM

According to the National Survey of Early Childhood Health, 2000[3]:

- Parents of children 4-35 months of age most frequently have concerns about how the child behaves (48%), how the child talks and makes speech sounds (45%), the child's emotional well-being (42%), and how the child gets along with others (41%).
- Concerns about how the child behaves tend to increase with the child's age. Parents of about 56% of children 19-35 months of age have "a lot" or "a little" concern, compared with 35% of parents of children 4-9 months of age, and 44% of parents of children 10-18 months of age.
- 89% of parents of children 4-9 months of age said they had someone to turn to for emotional support. That figure dropped to 88% of parents of children 10-18 months of age and 84% of parents of children 19-35 months of age.
- 92% of parents of children 4-9 months of age said they had someone they could count on to watch the child if they needed a break. That figure dropped to 88% of parents of children 10-18 months of age and 87% of parents of children 19-35 months of age.
- Only 73% of parents of children 4-35 months of age said their child had the same bedtime every day; 66% had the same naptime every day; and 75% had the same mealtimes every day.

- 6% of parents of children 4-35 months of age said they never read to their child; 15% said they read to their child 1-2 days per week; 27% said they read to their child 3-6 days per week; and 52% said they read to their child every day.
- Only 52% of women with less than a high school education ever breastfed their child; 60% of women with a high school diploma breastfed; and 79% of women with more than a high school education breastfed.

NATIONAL / STATE GOAL

Healthiest Wisconsin 2010 Health Priority:

Access to Primary and Preventive Health Services
Mental Health and Mental Disorders

DATA DEPICTION

SPHERE mental health related data for children under three, for 2004, includes case management, counseling, health teaching, referral and follow-up, and screening. [4] Services provided directly to the child and/or parents included 14,626 case management activities for 4,985 clients, 2,032 counseling activities for 634 clients, 7,928 health teaching activities for 3,798 clients, 4,797 referral & follow-up activities for 2,716 clients, and 9,836 screening activities for 5,904 clients.

Case Management	Clients	Activities
Infant Assessment	1,521	2,212
Family Foundations (POCAN)	181	2,220
Postpartum Assessment	696	794
Postpartum Care Plan	211	245
Postpartum Ongoing Monitoring	339	656
Prenatal Assessment	19	22
Prenatal Care Plan	13	15
Prenatal Ongoing Monitoring	28	55
Targeted Case Management Assessment	270	1,090
Targeted Case Management Care Plan	185	401
Targeted Case Management Ongoing Monitoring	352	2,424
All Other	721	1,483

Counseling	Clients	Activities
Alcohol Use	15	16
Breastfeeding Support	45	66
Coping Techniques	206	500
Domestic Violence	15	23
Drug & Other Substance Use	13	16
Grief Support	311	1,272
Parent/Family Support	222	576
Safe Living Situation	29	32
Stress Management	89	140
Support System	155	238
All Other	359	542

Health Teaching	Clients	Activities
ATODA: Primary Prevention	9	9
Access to Care	298	356
Brain Development	922	1,433
Breastfeeding Promotion	237	272
Breastfeeding Support	454	632
Child Abuse	34	42
Child Care/Day Care	156	212
Child Growth & Development	1,284	3,029
Child Health: Preschool Age	147	184
Chronic Behavioral Condition(s)	6	6
Chronic Emotional Condition(s)	24	42
Chronic Medical Condition	54	77
Community Resources	909	1,187
Depression	150	210
Domestic Abuse	35	37
Emotional Health	143	235
Fetal Alcohol Syndrome	16	16
Home Safety	852	1,057
Infant Care	1,608	2,484
Mental Health Primary Prevention	19	24
Parenting	1,373	2,721
Perinatal Depression	523	576
Self-Esteem	18	27
Social Support	135	198

Referrals & Follow-up	Clients	Activities
Birth to 3/Early Intervention	484	624
Child Care	88	117
Child Care Coordination	25	29
Child Protective Services	24	39
County Community Programs	245	381
County Social Services	113	165
Domestic Violence Services	18	24
Family Support Program	120	149
First Step	20	24
Head Start	39	47
Local Health Department	857	1,077
Mental Health	48	73
Parent to Parent	60	64
Parenting Program	263	361
Regional CSHCN Center	82	94
Respite Care	44	53
Support Group	78	82
WIC	620	762

Screening	Clients	Activities
Depression	51	61
Developmental Assessment	2,012	3,210
Family Questionnaire	97	106
Family Support Scale	25	27
Feeding Assessment	418	683
Feeding Relationship	129	180
Head Circumference	644	961
Hearing	104	118
Height/weight	1,296	2,258
Infant Assessment	2,329	3,042
Mental Health	5	5
Newborn Hearing	9	9
Parent-Child Interaction (NCAST)	89	105
Postpartum Assessment	106	118
Vision	65	66

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[4] The Wisconsin Title V Maternal and Child Health data system known as SPHERE (Secure Public Health Electronic Record Environment) collects information from POCAN and Home Visitation Outcomes Projects, All Title V funded projects (local health departments and private non-profits including CSHCN Regional Centers and Regional Center Contractees), and Tribal Agencies (Honoring our Children). POCAN is the acronym for the comprehensive targeted home visiting program authorized under 46.515 Wisconsin statutes and stands for Prevention of Child Abuse and Neglect.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Adolescent mental health

DEFINITION

One measure of adolescent mental health is the suicide rate (per 100,000) among adolescents, 15-19. Other measures are the reduction of the proportion of adolescents who reported to be sad, unhappy, or depressed, and the prevalence estimates of children and adolescents with a serious mental disorder.[1]

DESCRIPTION OF THE NEED

The social-cultural environment of family, peers, school, home, and community must be considered in understanding mental disorders in children and adolescents. Focusing on diagnostic labels alone provides too limited a view of mental disorders in children and adolescents.[1] Adolescence is a developmental period during which many changes take place. Some teenagers experience adolescence as stressful and they experience feelings of hopelessness. These feelings could be a precursor to suicide or suicide ideation.[2] The suicide rate among adolescents has increased from 8.7 in 1999 to 10.5 in 2002. From 1995-2002, the largest number of suicide-related hospitalizations occur in the 15-24 age group.[3]

The definition used by the Department of Health and Family Services (DHFS) for children with a serious mental disorder is nearly identical to the one used by the national Center for Mental Health Services. The individual must be under the age 21 with a disability evidenced by: 1) a condition that has persisted for 6 months and expected to remain for a year or longer; 2) have a defined serious emotional disturbance (SED) diagnosis for children and adolescents as prescribed the American Psychiatric Association categories; and 3) have functional symptoms and impairments that limit their ability to care for themselves, form social relationships, and manage family, school and work environments. The Wisconsin Bureau of Mental Health and Substance Abuse Services estimated that there are 49,984 children between ages 5-17 in 2002 with serious mental disorder. Not all of these children will require specialized services or institutional care, however for those that meet the lower functioning, it is about 35% of the total identified.[4]

SERIOUSNESS OF THE PROBLEM

The Wisconsin Youth Risk Behavior Survey (YRBS)[5] for 2003 reported that:

- 20% of students seriously considered suicide in the past twelve months
- 8% reported attempting suicide
- 25% of high school students had felt so sad or hopeless almost everyday for >2 weeks in a row that they stopped doing some of their usual activities
- Female students were more likely than male students to have felt sad or hopeless almost everyday for >2 weeks.

From the SLAITS Survey of Children with Special Health Care Needs (CSHCN)[6]:

- 21% of CSHCN nationally reported use or need for emotional, behavioral or developmental services.
- 4.6% of CSHCN reported they needed mental health services but were unable to obtain mental health services.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Mental Health Status Improvement
Disabilities and Secondary Conditions

Healthiest Wisconsin 2010 Health Priority:

Access to Primary and Preventive Health Services
Mental Health and Mental Disorders

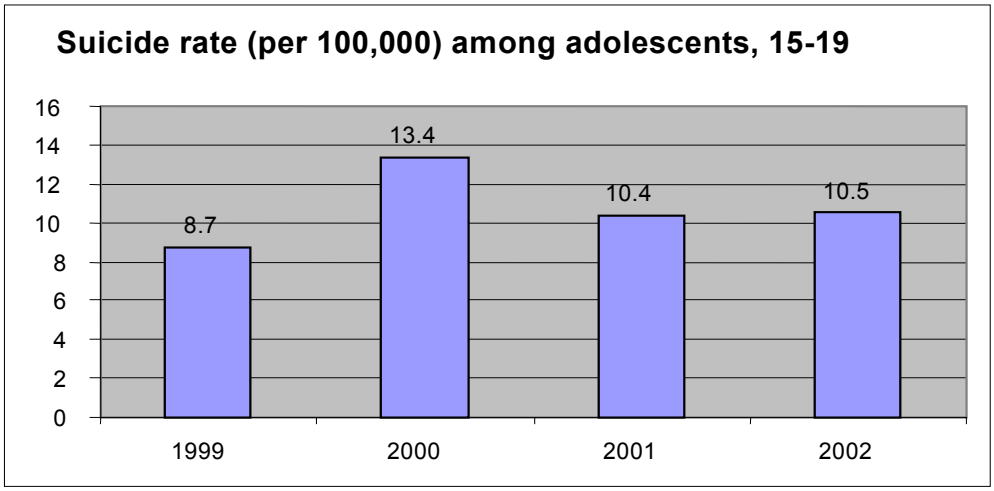
Title V National Performance Measure:

The rate (per 100,000) of suicide deaths among youths aged 15 through 19

DATA DEPICTION – Wisconsin data

Youth risk behavior indicators[5]	Total	Males	Females
Feeling sad or hopeless, two weeks in a row	25%	18%	34%
Considered suicide	20%	14%	26%
Attempted suicide	8%	5%	12%

Suicide rate (per 100,000) among adolescents, 15-19[3]	1999	2000	2001	2002
Number	36	51	43	43
Rate	8.7	13.4	10.4	10.5



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[1] Mental Health: A Report of the Surgeon General; Department of Health and Human Services; U.S. Public Health Service.
[2] Healthy Youth 2010: Supporting the 21 Critical Adolescent Objectives, American Medical Association, 2003.
[3] Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information.
[4] Fiscal Year 2005-2007 Wisconsin State Mental Health Plan; Bureau of Mental Health and Substance Abuse Services (DHFS).
[5] Wisconsin Department of Public Instruction. 2003 Wisconsin Youth Risk Behavior Survey. Executive Summary.
[6] Data derived from the State and Local Area Integrated Telephone Survey (SLAITS), National Survey of Children with Special Health Care Needs (CSHCN), conducted by CDC-NCHS in 2000-2002. Percents are weighted.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Immunizations in young children

DEFINITION

Percent of young children who have received the full schedule of age-appropriate immunizations against measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, haemophilus influenza, and hepatitis B.

DESCRIPTION OF THE NEED

The CDC 2003 National Immunization Survey estimates immunization levels among children 24 months of age in Wisconsin who are series complete, is 81.2%. Series complete is defined as 4 DTaP, 3 Polio, 1 MMR, 3 Hib, and 3 Hepatitis B doses. The remaining 18.8%, or approximately 20,000 children, are not properly immunized. In addition, children 24 months of age who are enrolled in Medicaid have a series complete immunization level of only 55%, based on immunization data from the Wisconsin Immunization Registry: the goal is 90%.[1]

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Diseases Preventable through Universal Vaccination

Healthiest Wisconsin 2010 Health Priority:

Existing, emerging, and re-emerging communicable disease

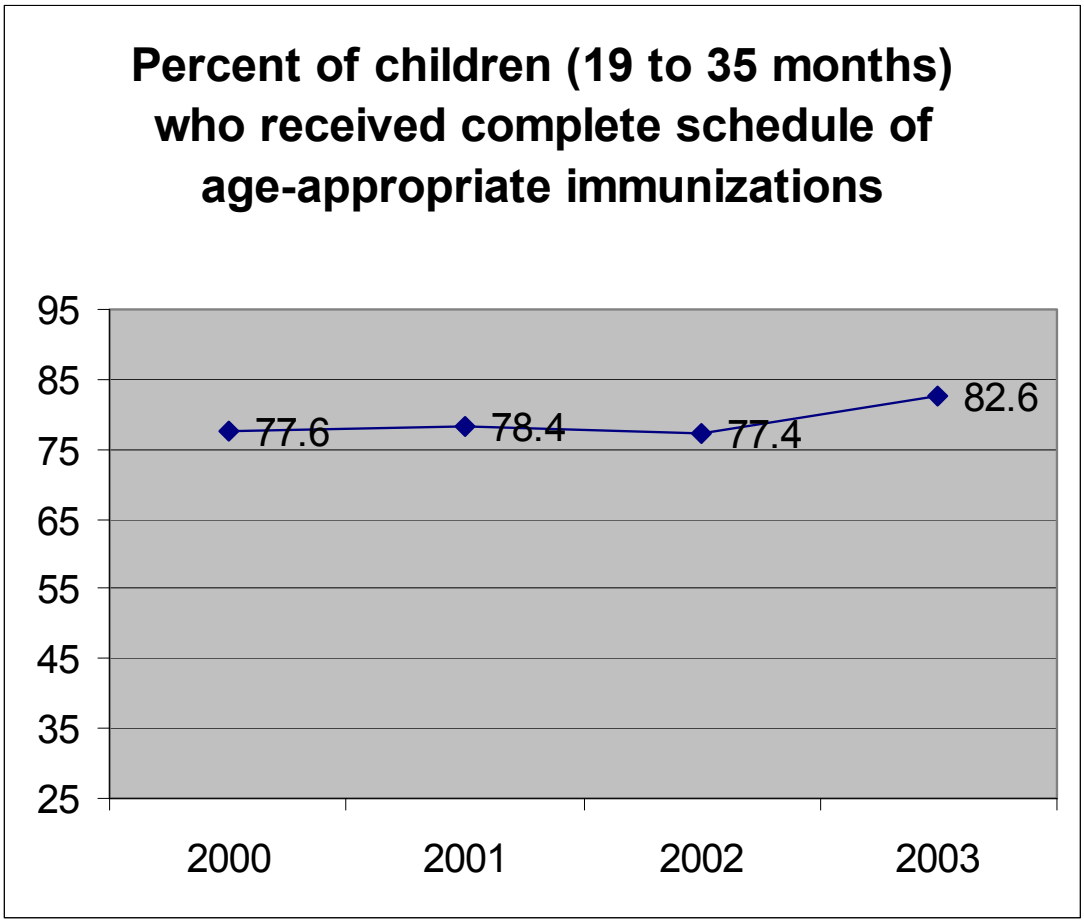
Title V National Performance Measure:

Percent of 19 to 35 month olds who have received full schedule of age-appropriate immunizations against measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, haemophilus influenza, and hepatitis B

DATA DEPICTION

Percent of children (19-35 months), who have received full immunization schedule.[2]

2000	2001	2002	2003
77.6%	78.4%	77.4%	82.6%



DATA SOURCE

[1] Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Communicable Diseases and Preparedness, Immunization Program, September 2004.

[2] Data are from the Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Communicable Diseases and Preparedness, Immunization Program. The data are compiled annually from the Centers for Disease Control and Prevention's National Immunization Survey.

[3] Bureau of Communicable Disease, Wisconsin Department of Health and Family Services from the National Immunization Survey, Centers for Disease Control and Prevention.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

CSHCN have adequate insurance

DEFINITION

Percent of families of children with special health care needs (CSHCN) who have adequate private or public insurance to pay for the services they need. This is measured by the State and Local Area Integrated Telephone Survey (SLAITS). An affirmative response combines answers to "Has insurance at time of survey", "Has no gaps in coverage during past year", "Insurance covers needs", "Costs not covered by insurance are reasonable", "Insurance allows child to see needed providers".

DESCRIPTION OF THE NEED

Health insurance plays a critical role in removing financial barriers to care. Insured CSHCN are much more likely than their uninsured counterparts to have a usual source of care and to obtain needed medical care, dental care, mental health services, and prescription medications.[1,2,3] The important role played by insurance in enabling access, as well as the reduced risk of large out-of-pocket expenses, provides strong incentives for eligible CSHCN to be enrolled in public insurance. Compared with other children, CSHCN have higher rates of public insurance (29.8% vs 18.5%), lower rates of private insurance (62.5% vs 69.1%), and a smaller percentage without insurance (8.1% vs 11.5%). Among low income CSHCN, more than 13% were uninsured. However, the challenge to ensure that CSHCN have access to insurance, that the insurance is adequate to meet the needs of the child, and that there is not an undue burden on the family to provide coverage remains.[4] While nearly an estimated 93% of Wisconsin CSHCN reported not having a gap in coverage during the past year, only an estimated 67% of CSHCN met the Title V national performance measure on health insurance.

SERIOUSNESS OF THE PROBLEM

According to the National Health Interview Survey,[5] in 2002:

- When compared with children in excellent or very good health, children in fair or poor health were five times as likely to have unmet medical need, more than four times as likely to have had two or more emergency room visits, and 3.5 times as likely to have delayed health care.
- Children with no health insurance were 13 times as likely to not have a usual place of health care as children with private health insurance (27% versus 2%).
- Children who had no health insurance were more likely to receive their usual health care in an emergency room than children with either private insurance or Medicaid.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:
Primary Care

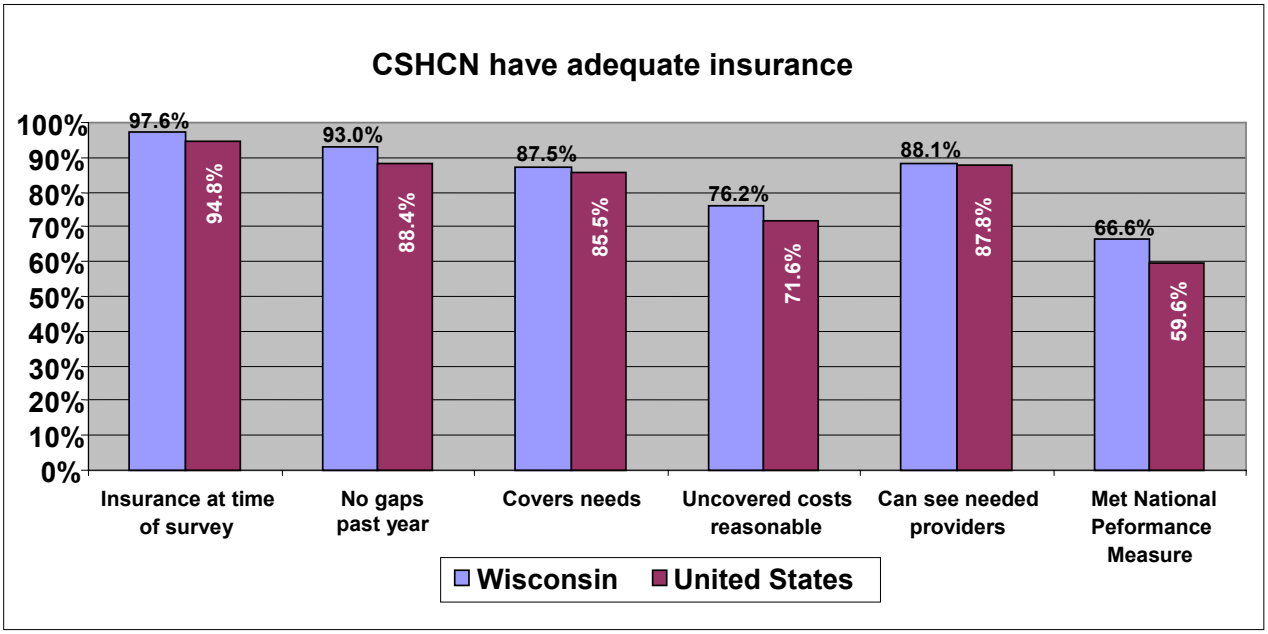
Healthiest Wisconsin 2010 Health Priority:
Access to Primary and Preventive Health Services

Title V National Performance Measure:
Percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

DATA DEPICTION-Wisconsin and U.S. data[6]

Percent of CSHCN whose families have adequate insurance[6]

	Wisconsin	U.S.
"Has insurance at time of survey"	97.6%	94.8%
"Has no gaps in coverage during past year"	93.0%	88.4%
"Insurance covers needs"	87.5%	85.5%
"Costs not covered reasonable"	76.1%	71.6%
"Insurance allows child to see needed providers"	88.1%	87.7%
Met National Performance Measure	66.6%	59.6%



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[1] Aday LA, Lee ES, Spears B, et.al.. Health insurance and utilization of medical care for children with special health care needs. *Med Care*. 1993; 31:1013-1026.

[2] Newacheck PW, McManus M, Fox HB, et al. Access to health care for children with special health care needs. *Pediatrics*. 2000; 105: 760-766.

[3] Sliver EJ, Stein REK. Access to care, unmet health needs, and poverty status among children with and without chronic conditions. Ambulatory *Pediatrics*. 2001;314-320.

[4] Davidoff AJ. Insurance for Children with Special Health Care Needs: Patterns of Coverage and Burden on Families to Provide Adequate Insurance. *Pediatrics*. 2004; 114: 394-403.

[5] Dey AN, Schiller JS, Tai DA. Summary Health Statistics for U.S. Children: National Health Interview Survey, 2002. National Center for Health Statistics. Vital Health Stat 10(221). 2004.

[6] Data derived from the State and Local Area Integrated Telephone Survey (SLAITS), National Survey of Children with Special Health Care Needs (CSHCN), conducted by CDC-NCHS in 2000-2002. Percents are weighted.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

CSHCN receive care in a medical home

DESCRIPTION OF THE NEED

A medical home is an approach to providing continuous and comprehensive primary care in a high-quality and cost-effective manner. The percent of children with special health care needs (CSHCN) who received care in a medical home is measured by the State and Local Area Integrated Telephone Survey (SLAITS). SLAITS data include responses to "Has usual source of sick-child care", "Has usual source of well-child care", "Has personal doctor", "Has no problem with referrals when specialists and referrals are needed", "Receives needed care coordination", "Doctors communicate when care coordination needed", and "Family-centered care received during at least one visit in past year."

DESCRIPTION OF THE NEED

In Wisconsin 13.4% of children have a special health care need. As defined by the federal Maternal and Child Health Bureau (MCHB), CSHCN have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition that require health and related services of a type or amount beyond that required by children generally. Nationally, it is estimated that CSHCN account for 80% of pediatric health care expenses. Families and health care providers are faced with the challenge of managing complex health care in a system that is ill equipped to provide chronic care management.

In a medical home, the provider and the child/youth and their family act as partners to identify and access all the medical and non-medical services needed for the child/youth to achieve maximum potential.[1] In Wisconsin, only 57% of CSHCN reported access to a medical home or met the performance measure.

SERIOUSNESS OF THE PROBLEM

Analyses of national SLAITS data[2] indicate that:

- Children without a medical home are twice as likely to experience delayed or forgone care
- Non-white children are significantly less likely to have a medical home.
- Poor children and children whose special health care needs have a significant adverse impact on their activity levels are more than twice as likely not to have a medical home, and to have unmet health care needs, as children whose special health care needs have no such impact.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:
Service Systems

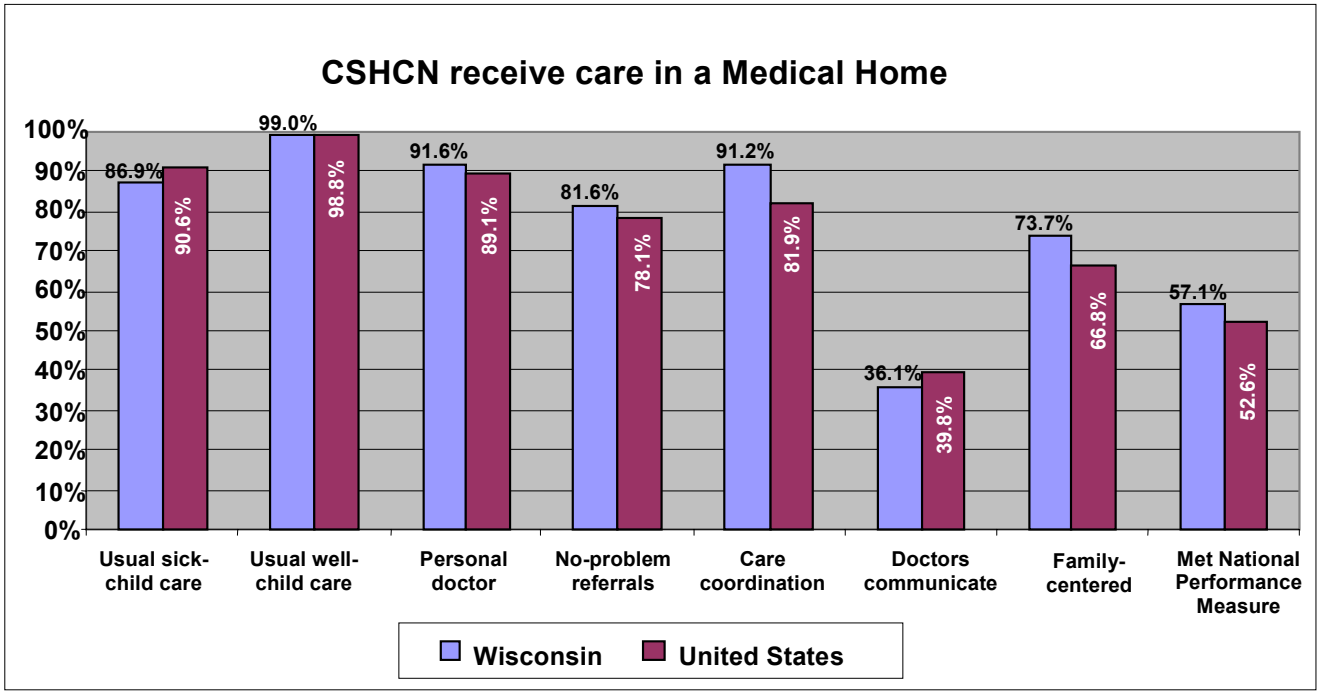
Healthiest Wisconsin 2010 Health Priority:
Access to Primary and Preventive Health Services

Title V National Performance Measure:
Percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

DATA DEPICTION - Wisconsin and U.S. data[3]

Percent of CSHCN who receive comprehensive care within a medical home[3]

	Wisconsin	U.S.
"Has usual source of sick-child care"	86.9%	90.6%
"Has usual source of well-child care"	99.0%	98.8%
"Has personal doctor"	91.5%	89.0%
"No problem with referrals"	81.6%	78.1%
"Receives needed care coordination"	91.2%	81.9%
"Doctors communicate"	36.1%	39.8%
"Family-centered"	73.6%	66.8%
Met National Performance Measure	57.1%	52.6%



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[2] Strickland B, McPherson M, Weissman G, et. al. Access to medical home: results of the national survey of children with special health care needs. *Pediatrics*. 2004; 113(suppl): 1485-1492.

[3] Data derived from the State and Local Area Integrated Telephone Survey (SLAITS), National Survey of Children with Special Health Care Needs (CSHCN), conducted by CDC-NCHS in 2000-2002. Percents are weighted.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

CSHCN families partner in decision-making and satisfied with services

DEFINITION

Percent of Children with Special Health Care Needs (CSHCN) whose families feel they are partners in decision making and are satisfied with the services they receive. This is measured by the State and Local Area Integrated Telephone Survey (SLAITS). An affirmative response combines an affirmative answer to "Doctors make parents feel like partners when at least one visit in past year" and an affirmative answer to "Family very satisfied with care experience".

DESCRIPTION OF THE NEED

In Wisconsin, 13.4% of children have a special health care need. As defined by the federal Maternal and Child Health Bureau (MCHB), children with special health care needs (CSHCN) have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition that requires health and related services of a type or amount beyond that required by children generally.[1] These health and related services must be family-centered and recognize families are the ultimate decision-makers for their children with special health care needs. Family-centered services are important to ensure that families are knowledgeable and satisfied with services. Knowledgeable and informed families are able to make informed health decisions and support their children to reach their optimal level of development. State specific data collected from the SLAITS survey found 66.6% of families in Wisconsin are satisfied with the services they receive and feel they are partners in decision making. Although this is higher than the overall national result of 57.5%, nearly one-third of families in Wisconsin are not satisfied with the services they receive or feel they are not part of the decision making process.

NATIONAL / STATE GOAL

Healthiest Wisconsin 2010 Health Priority:

Access to Primary and Preventive Health Services

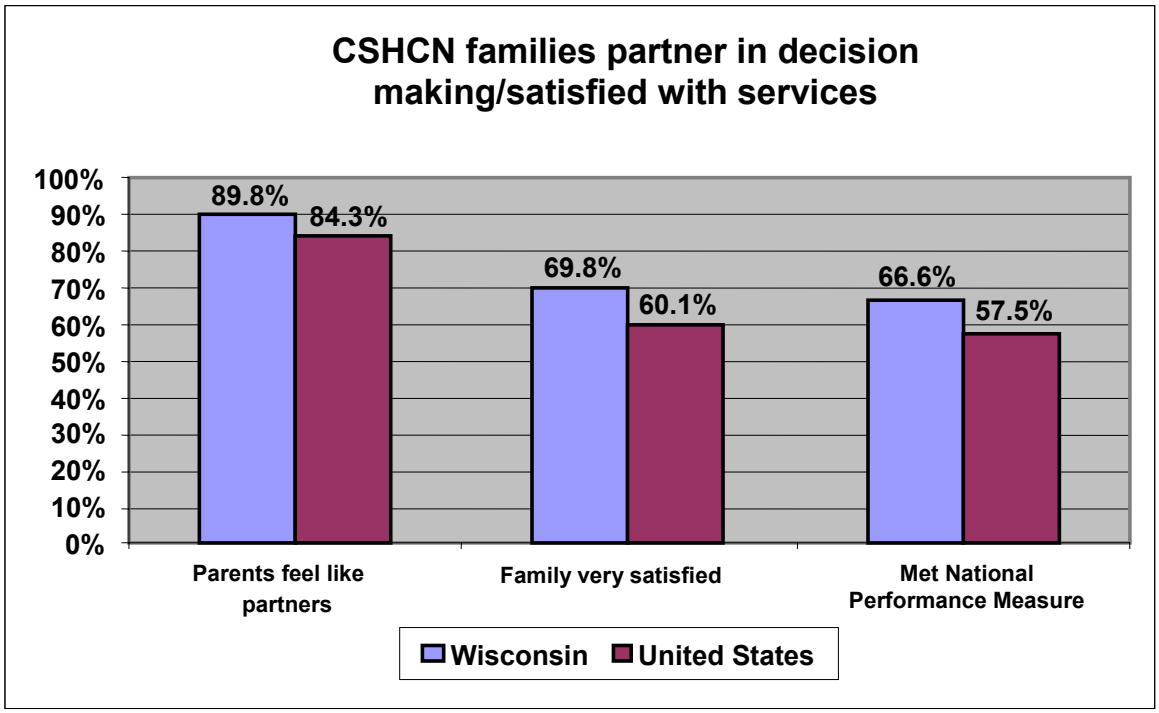
Title V National Performance Measure:

Percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive

DATA DEPICTION

CSHCN families partner in decision making and satisfied with services

	Wisconsin	U.S.
"Doctors make parents feel like partners"	89.8%	84.3%
"Family very satisfied"	69.8%	60.1%
Met NPM	66.6%	57.5%



DATA SOURCE

[1] "Prevalence and Characteristics of Children with Special Health Care Needs," by first author Peter C. van Dyck, M.D., M.P.H., associate administrator for maternal and child health at HHS' Health Resources and Services Administration (HRSA), published in September's issue of the American Medical Association's Archives of Pediatrics and Adolescent Medicine, http://archpedi.ama-assn.org/.

[2] Data derived from the State and Local Area Integrated Telephone Survey (SLAITS), National Survey of Children with Special Health Care Needs (CSHCN), conducted by CDC-NCHS in 2000-2002. Percents are weighted.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

CSHCN families have access to community-based services

DEFINITION

Percent of CSHCN families who have access to community-based services. Access means that community services are available and organized in a way that makes them easy to use. This is measured by the State and Local Area Integrated Telephone Survey (SLAITS). An affirmative response means the respondent said that community-based services are usually or always accessible.

DESCRIPTION OF THE NEED

According to the SLAITS Survey, 80.7% of families with CSHCN in Wisconsin report that community-based systems are organized so they can use them easily. Families identified this as a need in the early 1990s and the Wisconsin Title V MCH/CSHCN Program responded by creating five Regional CSHCN Centers. These centers provide information, referral and follow-up, parent support opportunities, training opportunities for families and providers, and service coordination to children with special health care needs and their families. The five Regional CSHCN Centers work collaboratively with local health departments and other community-based agencies, to establish a network of community-based agencies that families can be referred to for services needed, as well as determining areas of unmet needs to focus attention on. This is an area of ongoing assessment and monitoring. Parents of children with special health care needs are active participants in the work of the five Regional CSHCN Centers as staff members of the centers, as well as community-based parent liaisons to the local health department. As health care funding and the availability of resources and services for children with special health care needs change, it is critical to maintain the ability to assess and monitor the community-based service systems at the regional and local levels.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Service Systems

Healthiest Wisconsin 2010 Health Priority:

Access to Primary and Preventive Health Services

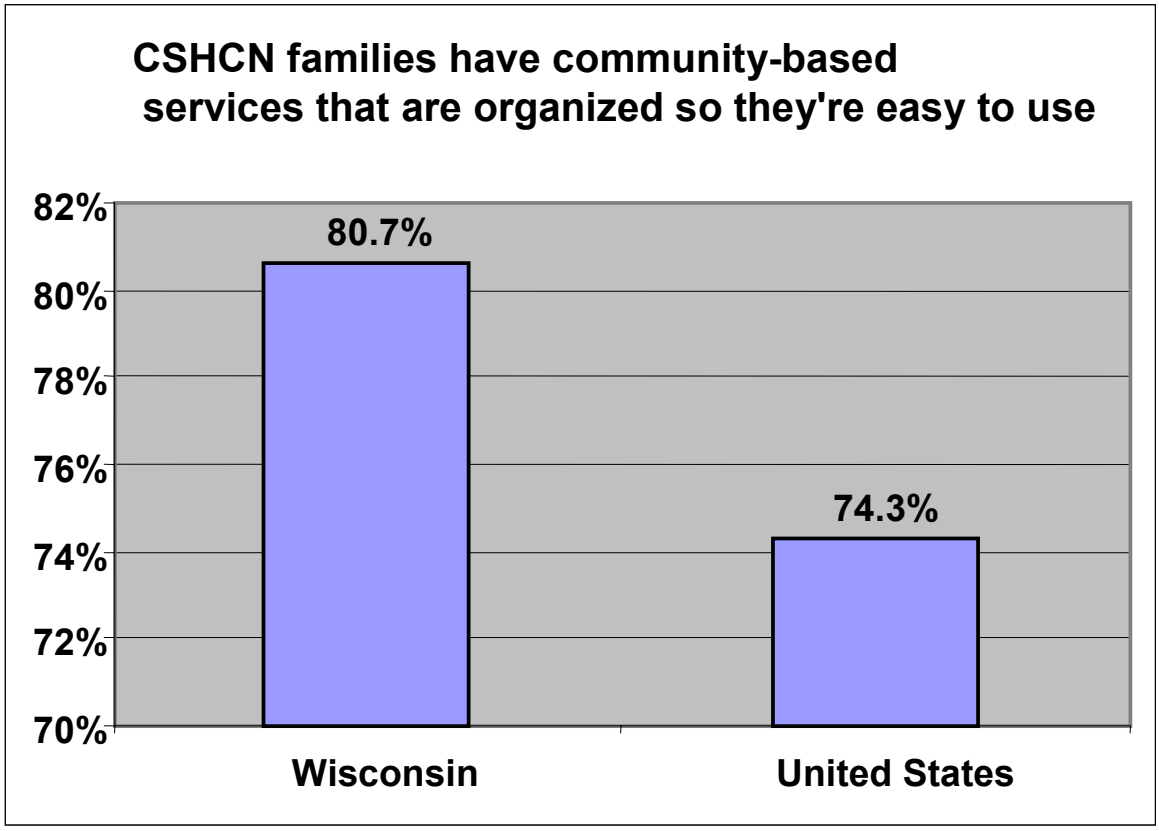
Title V National Performance Measure:

Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they are easy to use

DATA DEPICTION[1]

Percent of CSHCN families who have access to community-based services.

Wisconsin	U.S.
80.7%	74.3%



DATA SOURCE

[1] Data derived from the State and Local Area Integrated Telephone Survey (SLAITS), National Survey of Children with Special Health Care Needs (CSHCN), conducted by CDC-NCHS in 2000 – 2002. Percents are weighted.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

YSHCN receive services to make transition to adulthood

DEFINITION

Percent of YSHCN who receive services to make transition to adulthood. Transition services encompass the change in needed health services as a child matures to adulthood, and services that prepare a child to live in the adult world. An affirmative response combines answers to "Receives guidance on transition to adulthood" and "Receives training to prepare for adult job".

DESCRIPTION OF THE NEED

Transition to adulthood presents many challenges for CSHCN, especially those with significant impairments. Many do not graduate from high school. Most do not receive post secondary education, and many, even if they are employed, never earn a wage that allows them to be self-supporting. Nationally only 30% of adults with disabilities are employed. While 11.4% of Wisconsin students were identified as disabled during the 1998-99 school year (Department of Public Instruction data), these students accounted for 28% of students who dropped out of school. Although health influences all areas of their future, students leave high school with little or no experience in managing their own health care. Many times health-related factors are not included in the Individual Education Plan (IEP) or included in other transition planning for these students, failing to explore how the student's special health needs may impact post secondary education, vocational training, employment, and most aspects of independent living.

According to weighted data from the National Survey of Children with Special Health Care Needs (SLAITS) released in 2003, only 7.5% of youth 13-17 years of age reported receiving transition services. The survey asked about vocational training; assistance in planning for changing needs; and opportunities to discuss future health needs with their doctors and obtain their assistance in transferring to adult care providers. Less than 16% of CSHCN youth reported receiving appropriate guidance and support in the medical aspects of the transition to adulthood. In addition, only 29.3% received at least some vocational or career training. Successful transition to adult life is a key component of the federal Healthy People 2010 objectives. Collaboration across state departments of Public Instruction, Work Force Development, and Health and Family Services will be critical to assure access to comprehensive resources, information, and services for parents and youth, and to training, information resources, and technical assistance for teachers, health care and community service providers.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Disability and Secondary Conditions

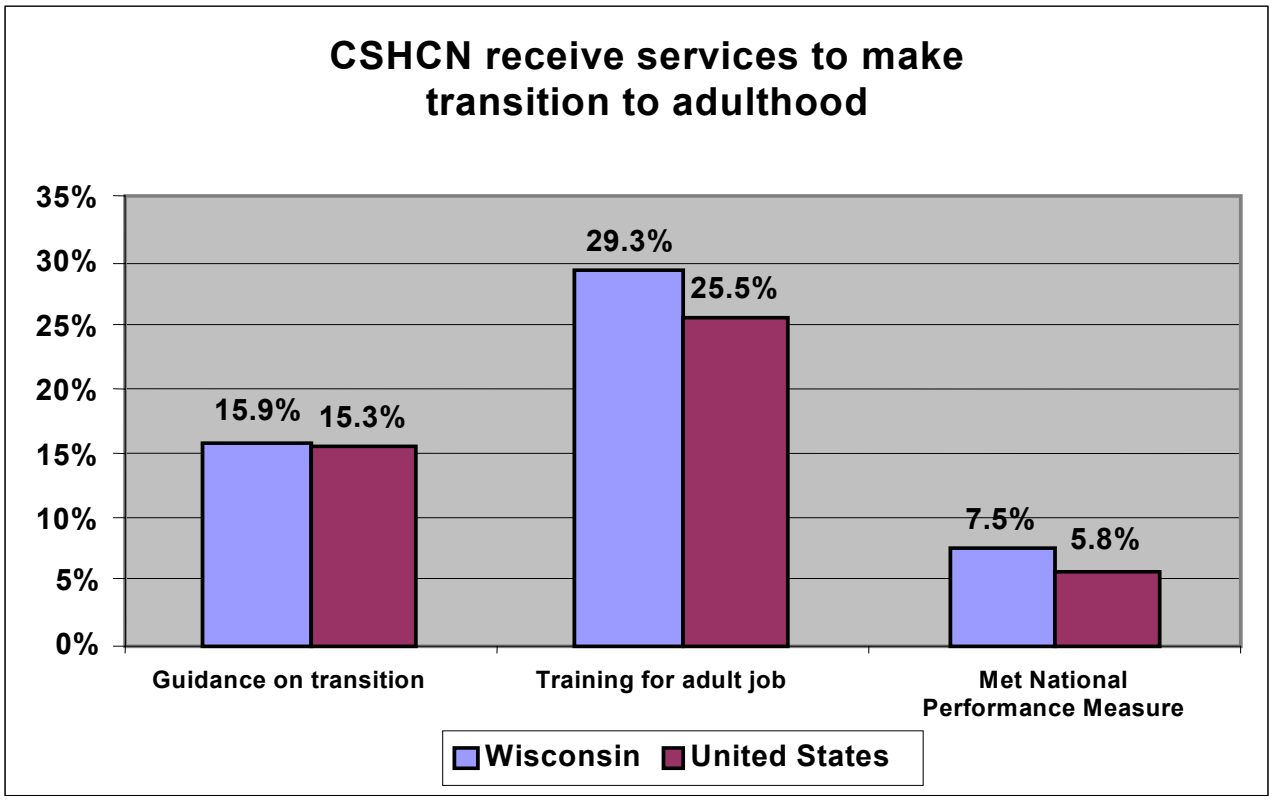
Title V National Performance Measure:

Percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life.

DATA DEPICTION[1]

Percent of YSHCN who receive services to make transition to adulthood.

	Wisconsin	U.S.
"Guidance on transition to adulthood"	15.9%	15.3%
"Training to prepare for adult job"	29.3%	25.5%
Met NPM	7.5%	5.8%



DATA SOURCE

[1] Data derived from the State and Local Area Integrated Telephone Survey (SLAITS), National Survey of Children with Special Health Care Needs (CSHCN), conducted by CDC-NCHS in 2000 – 2002. The reference population was restricted to CSHCN age 13 and older. Percents are weighted.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

CSHCN access to dental care

DEFINITION

Percent of CSHCN who report they needed dental services.
Percent of CSHCN who report they received all needed dental services.

DESCRIPTION OF THE NEED

Results of the 1994-1995 National Health Interview Survey on Access to Care and the Use of Services by Children with Special Health Care Needs indicate that the most prevalent unmet need is dental care.[1]

Infants and young children with special health care needs may be at risk for a variety of oral conditions relating to oral development, oral trauma, grinding of teeth (bruxism), oral infections, and gum overgrowth. These conditions affect nutritional status, self esteem and a child's ability to participate in the learning process. Many infants and young children with special health care needs may not be referred to a dentist until an oral health problem affects their overall health. Nationally, it is estimated that for every medically uninsured person, there are 2.6 people without dental insurance. All criteria for adequate insurance are not usually or always met for 11.9% of children with special health care needs.

Families and advocates for children with special health care needs may have difficulty identifying oral health care providers that are experienced in treating children with special health care needs. A 2002 Wisconsin Dentist Workforce Report by the Wisconsin Primary Health Care Association, revealed 4% of all dentists in Wisconsin are pediatric dentists. The Workforce Report also indicates that an estimated 56 new dentists will enter practice in Wisconsin each year between 2000 and 2010. However, higher numbers of dentists plan to leave practice with a net deficit of 153 fewer dentists in five years, and 436 fewer in ten years. This affects youth access to oral health prevention and treatment.

Integrating preventive oral health measures into healthcare and public health practice to assure access to fluoride and dental sealants are of highest priority for children with special needs to prevent the incidence of oral disease. Healthcare professionals can play a significant role in preventing oral disease by providing oral screenings, fluoride varnish applications, and providing parents/caregivers with oral health information.

Although 92.6% of Wisconsin CSHCN who said they needed dental services received those services, the 7.4% who did not receive needed services may well be children whose physical and/or behavioral challenges make it difficult to find a dentist willing and able to treat them.

NATIONAL / STATE GOAL

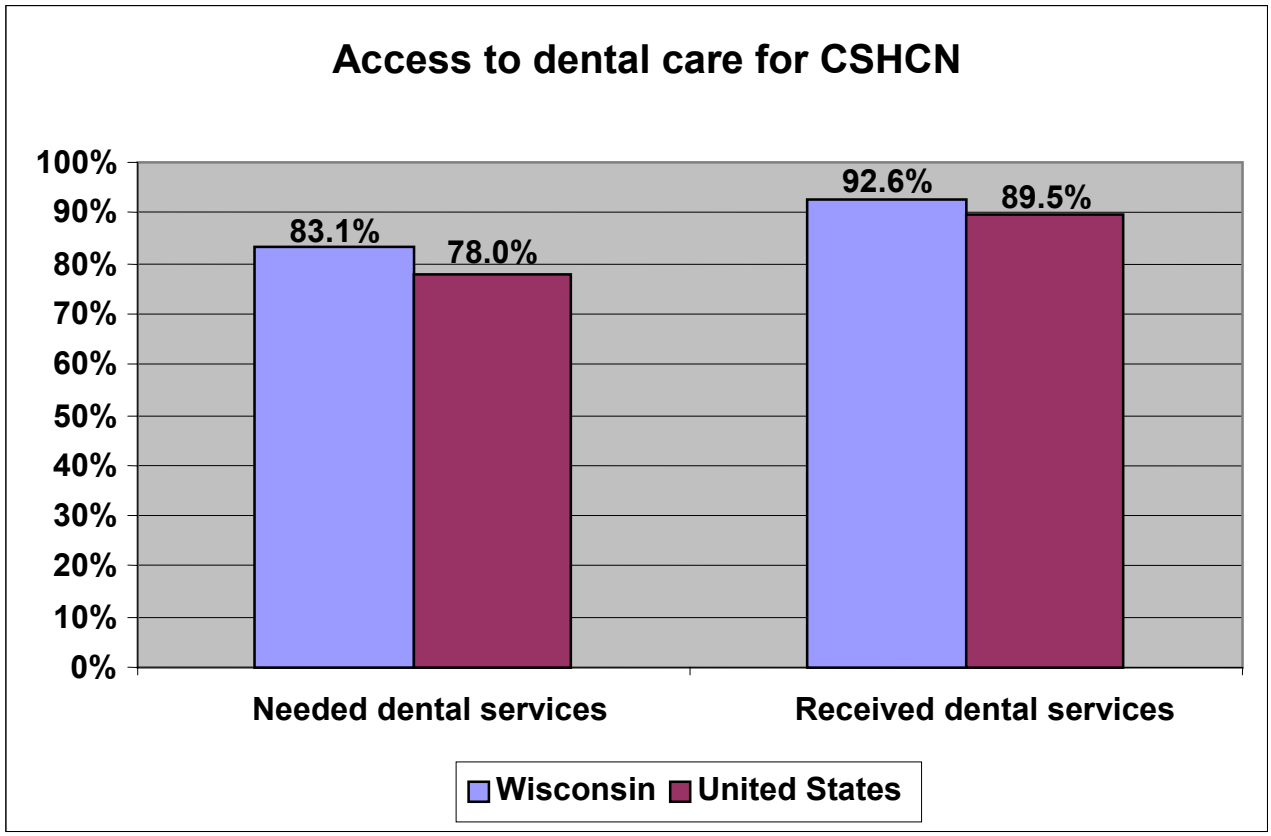
Healthiest Wisconsin 2010 Health Priority:

Access to primary and preventive health services, Objective 4 (oral health)

DATA DEPICTION

Access to dental care for CSHCN

	Wisconsin	U.S.
Needed dental services	83.1%	78.0%
Received all needed dental services	92.6%	89.5%



DATA SOURCE

[1] National Health Interview Survey (NHIS), U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Hyattsville, MD 20782.

Data derived from the State and Local Area Integrated Telephone Survey (SLAITS), National Survey of Children with Special Health Care Needs (CSHCN), conducted by CDC-NCHS in 2000-2002. Percents are weighted.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Asthma hospitalization for children

DEFINITION

Number and rate per 10,000 children, by age and race/ethnicity hospitalized for asthma (ICD-9 CM Codes 493.00-493.92).

DESCRIPTION OF THE NEED

Asthma is a chronic lung condition affecting children and adults that can result in hospitalization or even death. Many asthma hospitalizations represent repeat admissions for asthma that is not well self-managed and/or medically treated. Wisconsin's racial minorities and children represent a disproportionate share of asthma costs. The African American population in Wisconsin has the highest prevalence of asthma, is hospitalized at six times the rate of the White population, and has a four-fold higher rate of asthma mortality. The Native American population also has an elevated asthma prevalence and asthma hospitalization rate compared to the White population. Children, particularly those four years and younger, have the highest hospitalization (28 hospitalizations per 10,000 in 2002) and emergency room visit rates. Certain counties in the state carry a higher burden of asthma. Milwaukee County had both the highest asthma hospitalization (2000-2002) and asthma hospital emergency room visit rates (2002). Menominee County had the second highest rates for both of these measures of asthma health care utilization. The highest asthma mortality rate (1990-2001) was seen in Buffalo County.[1]

Current asthma prevalence among children (0-17) by race of household adult respondent, 2002[1]

Race / Ethnicity	%
Non-Hispanic White	6%
Non-Hispanic Black	11%
Other*	6%
All Children	6%

*Note: The "Other" category is comprised of non-Hispanic Asians, non-Hispanic Native Hawaiians, Non-Hispanic Pacific Islanders, non-Hispanic Native Americans, non-Hispanic Alaskan Natives, Hispanics, multiracial respondents and individuals that reported being of other races. These groups were combined due to low number of survey respondents (n <100).

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:

Respiratory Diseases

Healthiest Wisconsin 2010 Health Priority:

Environmental and Occupational Health Hazards

DATA DEPICTION

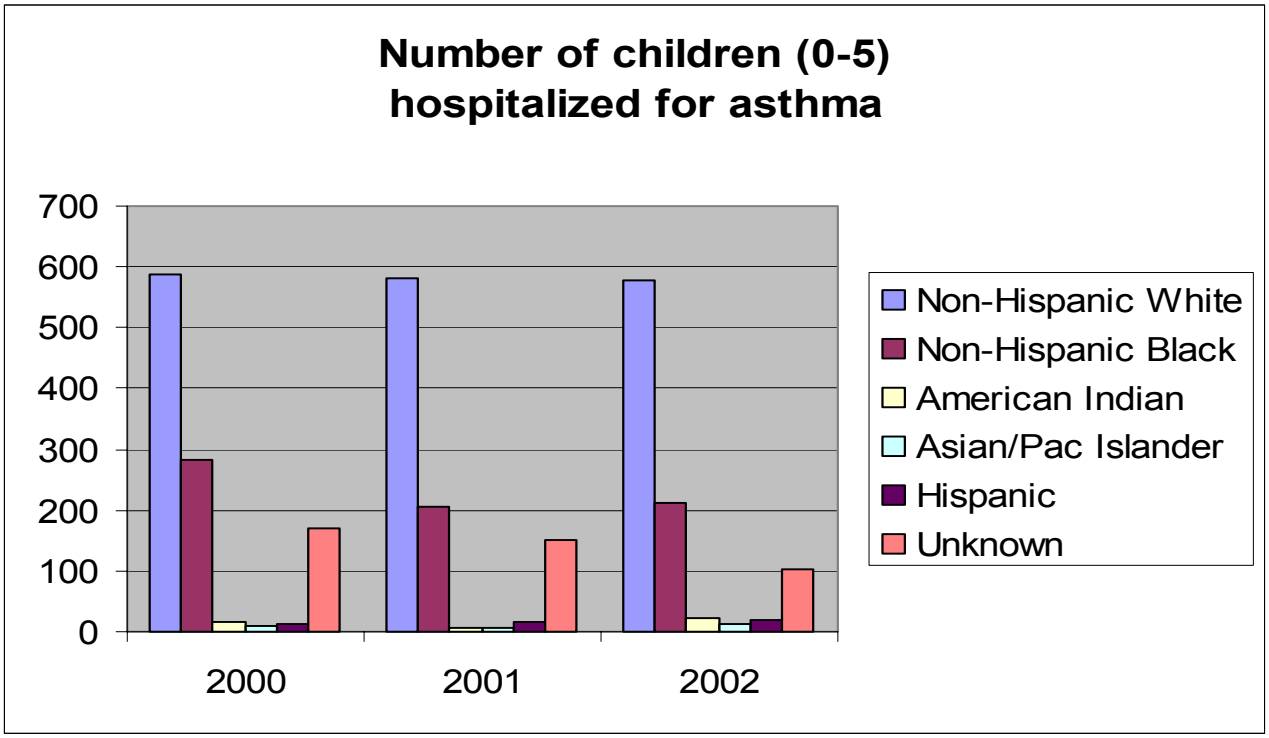
Number and rates per 10,000 children (0-5) hospitalized for asthma[2]

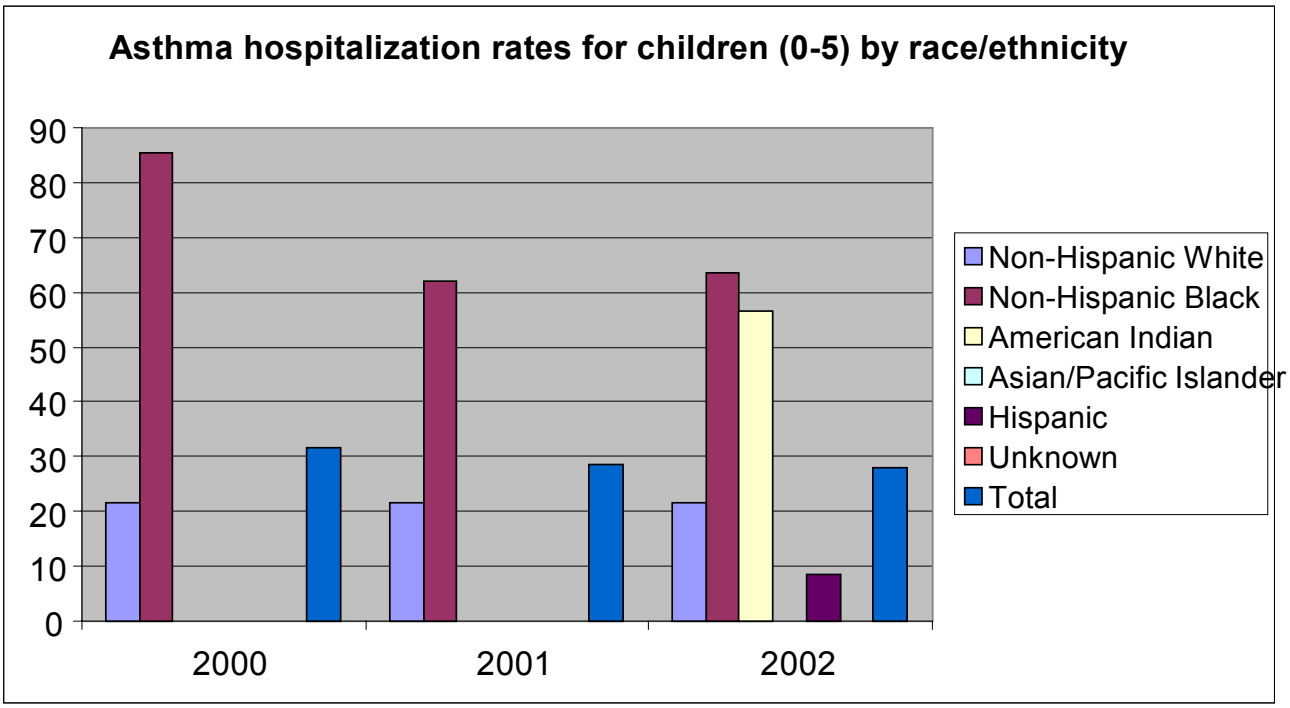
Race / Ethnicity	2000 #	2000 Rate/10,000	2001 #	2001 Rate/10,000	2002 #	2002 Rate/10,000
Non-Hispanic White	587	21.7	582	21.6	579	21.5
Non-Hispanic Black	282	85.4	207	61.9	212	63.6
American Indian	17	-	17	-	23	56.7
Asian / Pacific Islander	9	-	6	-	12	-
Hispanic	14	-	17	-	20	8.4
Unknown	170		151		103	-
Total	1,079	31.5	980	28.6	949	27.9

Note: Rates are not calculated for groups with less than 20 events or for the group of unknown race/ethnic origin.

Number and rates per 10,000 children hospitalized for asthma by age group, 2002[3]

Age	Number	Rate/10,000
29 - 365 days	184	27.1
1 - 4 years	800	29.4
5 - 9 years	416	11.6
10 - 14 years	265	6.6
15 - 19 years	180	4.4
20 - 24 years	167	4.1





DATA SOURCE / TEXT REFERENCES

[1] Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Environmental Health. *Burden of Asthma in Wisconsin—2004* PPH 45055 (03/04).

[2] Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Environmental Health. Denominators to calculate rates from Division of Public Health, Bureau of Health Information and Policy.

[3] Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, WITHIN for the Health Data Specialist (WITHIN), http://www.dhfs.state.wi.us/healthcareinfo/qsmain.htm, accessed 10/22/04.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Health insurance coverage

DEFINITION

Percent of children, ages 0-17, without health insurance all or part of the year.
Percent of women, ages 18-44, without health insurance all or part of the year.

DESCRIPTION OF THE NEED

There is a strong relationship between health insurance coverage and access to healthcare. Having health insurance increases the likelihood of receiving primary and preventive care. Studies indicate that uninsured children are:

- less likely to have preventive and primary care than insured children.
- less likely to have a relationship with a primary care physician.
- less likely to receive care for their health problems when ill.

Compared to other states, Wisconsin ranks high in the proportion of people who have health insurance. However, statewide data indicate that those less likely to be insured for the entire year were: adults aged 18 to 44; the poor and near poor; those in minority groups; those with less than a high school diploma; and children living with no employed adult. Women, ages 18-44, are slightly less likely to have health insurance than men of the same age.

The proportions of racial/ethnic minority groups that were continuously uninsured for an entire 12-month period were the following: Hispanics/Latinos (13%), African Americans (10%), American Indians and Asians (7%). By comparisons, 4% of Whites are uninsured for an entire year.[1]

SERIOUSNESS OF THE PROBLEM

According to the National Health Interview Survey,[2] in 2002:

- 7.1 million children (10%) had no health insurance coverage.
- Fourteen percent of children in families with an income less than $20,000 and 17% of children in families with an income of $20,000–$34,999 had no health insurance compared with 3% of children in families with an income of $75,000 or more.
- Children in poor and near poor families were more likely to be uninsured, to have unmet medical needs, delayed medical care, no usual place of health care, and high use of emergency room service than children in families who were not poor.
- Regionally, higher proportions of children in the West (13%) and South (12%) were uninsured than children in the Midwest (6%) or Northeast (6%). In addition, children in the West were less likely to have had a usual place of health care than children in any other region.
- Nearly 2 million children (2%) were unable to get needed medical care because the family could not afford it, and medical care for 3 million children (4%) was delayed because of worry about the cost.
- Overall, 6% of Americans delayed medical care in the past year for reasons associated with cost, while 4% did not receive needed medical care due to cost.
- Females were slightly more likely to delay medical care or not receive it when necessary, while persons aged 18-44 and 45-64 years were more likely to delay care than persons in other age groups.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:
Primary Care

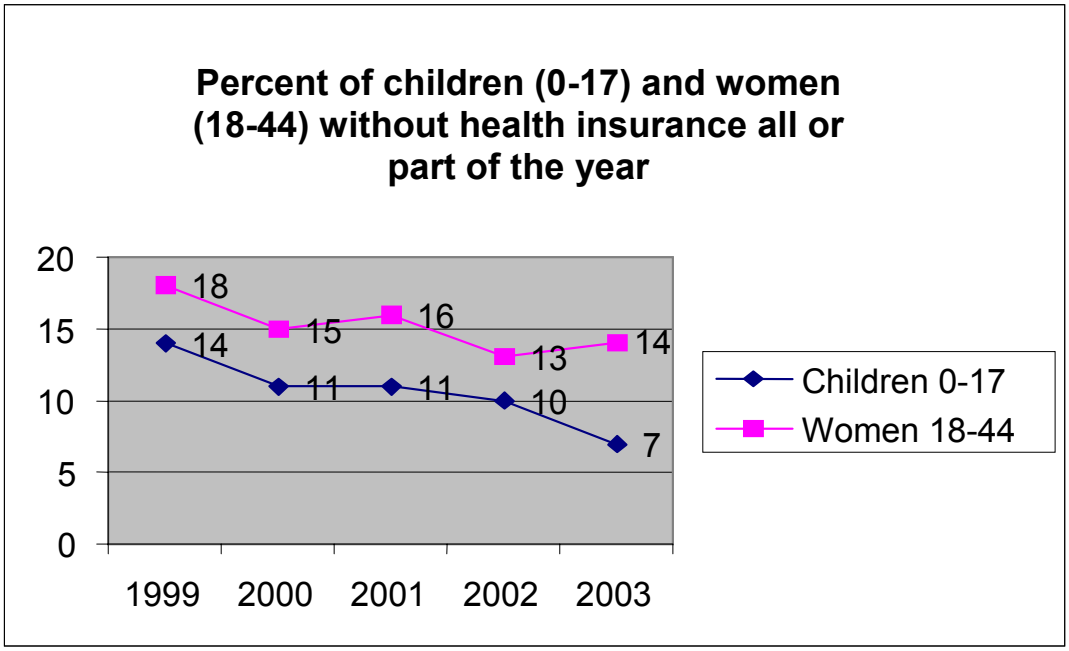
Healthiest Wisconsin 2010 Health Priority:
Access to Primary and Preventive Health Services

Title V National Performance Measure:
Percent of children without health insurance

DATA DEPICTION – Wisconsin data[3]

Percent with no health insurance coverage all or part of year

	1999	2000	2001	2002	2003
Children, ages 0 - 17	14%	11%	11%	10%	7%
Women, ages 18 - 44	18%	15%	16%	13%	14%



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[1] Wisconsin Department of Health and Family Services, Division of Public Health, Minority Health Program. *The Health of Racial and Ethnic Populations in Wisconsin: 1996-2000.*

[2] Dey AN, Schiller JS, Tai DA. Summary Health Statistics for U.S. Children: National Health Interview Survey, 2002. National Center for Health Statistics. Vital Health Stat 10(221). 2004.

[3] Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information, Family Health Surveys, 1999–2003.

WISCONSIN DIVISION OF PUBLIC HEALTH DATA DETAIL SHEET

Access to health care for children

DEFINITION

Full access is defined as comprehensive services with culturally competent high quality medical care (i.e., enabling services that encourage seeking primary and preventive services on a regular basis– interpretation, transportation, outreach, case management; regular contact with health promotion and health education services that are critical to promoting healthy behavior; and support services such as housing assistance, benefits counseling, child care, and food supports programs).[1]

The Wisconsin Title V Maternal and Child Health Annual Block Grant Application and Report uses the measure: **Percent of children less than 12 years of age who receive one physical exam a year** as one indicator for access to health care for children.

DESCRIPTION OF THE NEED

Regular well-child physical examinations, received through primary care services, result in early detection and treatment of health problems and reduces avoidable hospitalizations or long-term complications of many conditions. According to the Wisconsin Department of Health and Family Services Family Health Survey in 2002, 74.4% of children under 12 years of age reported (at the time of the telephone survey) that they had a general physical exam in the past year.[2]

SERIOUSNESS OF THE PROBLEM

According to the National Health Interview Survey,[3] in 2002:

- One-quarter of all children had no contact with a doctor or other health professional at any time during the past 6 months.
- Over three-quarters of children with private health insurance or Medicaid had contact with a doctor or other health professional in the past 6 months compared with about one-half of children with no insurance coverage.
- Fifteen percent of uninsured children had not had contact with a doctor or other health professional in more than 2 years (including those who never had a contact) compared with 3% for children with private insurance coverage or children with Medicaid.
- The percent of children who had contact with a doctor or other health professional at some time during the past 6 months increased as the level of parent's education increased.
- Children in poor and near poor families were more likely to be uninsured, to have unmet medical needs, delayed medical care, no usual place of health care, and high use of emergency room service than children in families who were not poor.
- Children in single-parent families were about twice as likely to have been unable to get medical care or to have delayed medical care compared with children in two-parent families.
- Children in single-mother families were almost twice as likely to have had two or more visits to an emergency room in the past 12 months compared with children in two-parent or single-father families.

NATIONAL / STATE GOAL

Healthy People 2010 Chapter:
Clinical Preventive Care and Primary Care

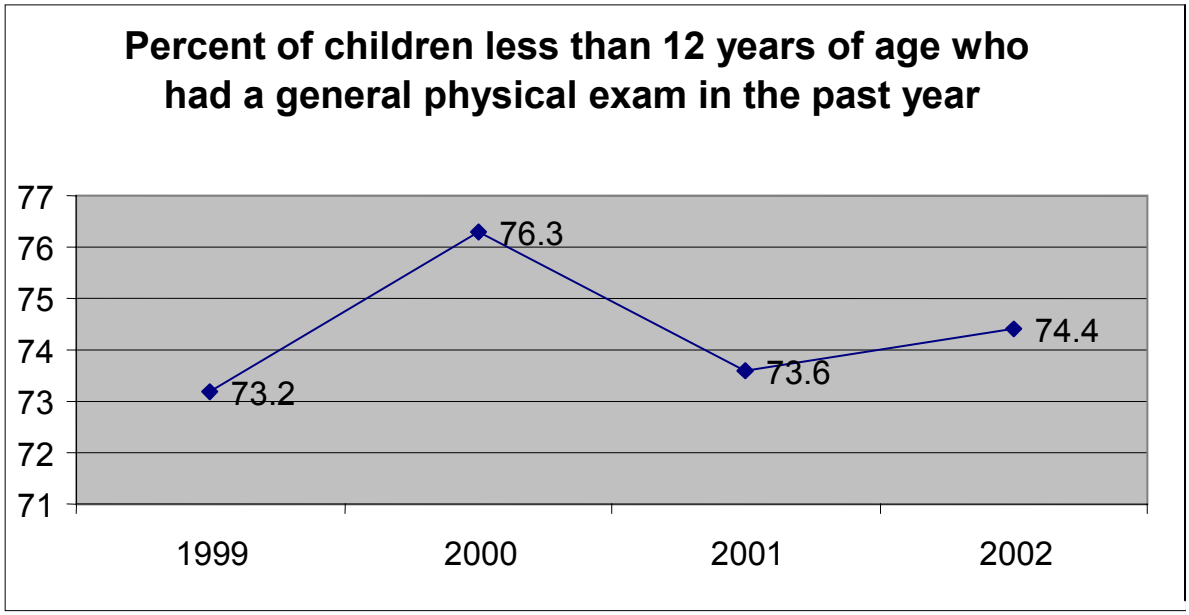
Healthiest Wisconsin 2010 Health Priority:
Access to Primary and Preventive Health Services

Title V State Performance Measure:
Percent of children less than 12 years of age who receive one physical exam a year

DATA DEPICTION – Wisconsin data[2]

Percent of children less than 12 years of age who had a general physical exam in the past year

Year	1999	2000	2001	2002
Percent	73.2%	76.3%	73.6%	74.4%



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[1] HRSA Workgroup for the Elimination of Health Disparities. *Eliminating Disparities in the United States.* November 2000. Available at http://www.hrsa.gov/OMH/OMH/disparities/default.htm. Cited in Wisconsin Department of Health and Family Services, Division of Public Health, Minority Health Program. *The Health of Racial and Ethnic Populations in Wisconsin: 1996-2000.* Madison, Wisconsin.

[2] Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information, Family Health Surveys 1999-2002.

[3] Dey AN, Schiller JS, Tai DA. Summary Health Statistics for U.S. Children: National Health Interview Survey, 2002. National Center for Health Statistics. Vital Health Stat 10(221). 2004.